|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | PATIENT REGISTRATION |  |  |  | DATE \_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |
|  | NAME |  |  |  | AGE |  | DATE OF BIRTH |
|  |  |  |  |  |  |  |  |  |
|  | ADDRESS |  |  |  |  |  | E-MAIL ADDRESS |
|  |  |  |  |  |  |  |
|  | CITY |  | STATE | ZIP | SSN# |
|  |  |  |  |  |  |  |  |  |
|  | PHONE (HOME) | (CELL) | (WORK) |  |  |  | OCCUPATION/EMPLOYER |
|  |  |  |  |  |  |  |  |
|  | SPOUSE’S NAM(CELL) | (WORK) |  |  |  | OCCUPATION/EMPLOYER |
|  |  |  |  |  |  |  |  |
|  | IF UNDER 18 PARENT/GUARDIAN |  |  |  |  |  |
|  |  |  |  |  |
|  | EMERGENCY CONTACT (OTHER THAN SPOUSE) RELATION | ADDRESS | PHONE |
|  |  |  |  |
|  |  |  | **PLEASE CHECK THE AREAS YOU WOULD LIKE TO DISCUSS** |
|  |  |  |  |  |  |  |
|  | **FACE** | **BODY** |  | **RECONSTRUCTIVE** | **MISCELLANEOUS** |
|  | ( ) Facelift | ( ) Tummy Tuck | ( ) Hand |  | ( ) Botox |
|  | ( ) Eyelid | ( ) Breast Augmentation | ( ) Cancer |  | ( ) Injectable |
|  | ( ) Nose | ( ) Body Lift |  | ( ) Scar Revision |  | ( ) Doctor Visit |
|  | ( ) Chin/Cheeks | ( ) Gluteal Augmentation | ( ) Moles, etc. |  | ( ) Laser Resurface |
|  | ( ) Ear Reshaping | ( ) Liposuction |  | ( ) Wounds |  | ( ) Other |
|  | ( ) Tuck Up | ( ) Vaginal Rejuvenation |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  | **REFERRED BY:** |  |  |
|  |  |  |  |  |  |
|  | \* Doctor (name \_\_\_\_\_\_\_\_\_\_\_\_\_\_) |  |  | \* Attended Lecture \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | \* Friend (name \_\_\_\_\_\_\_\_\_\_\_\_\_\_) |  |  | \* Telephone Yellow Pages \_\_\_\_\_\_\_\_ |
|  | \* Family (name \_\_\_\_\_\_\_\_\_\_\_\_\_\_) |  |  | \* Other |  |  |
|  |  |  |
|  | PHARMACY NAME AND NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  | **INSURANCE BENEFITS** |  |  |
|  | PRIMARY |  |  |  |  | SECONDARY |  |  |
|  | *Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |  | *Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
|  | Name of Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Name of Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Policy Holder’s Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Relationship of Patient to Policy Holder \_\_\_\_\_\_\_\_ |  | Relationship of Patient to Policy Holder \_\_\_\_\_\_\_ |
|  | Policy Holder Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Policy Holder Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize direct payment of surgical/medical benefits to Y Plastic and Reconstructive Surgery.

Payment is required for all services at the time they are rendered unless you are in a plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. I understand that I am financially responsible for any balance not covered by my insurance.

Should the account become delinquent and fall into collections I will be responsible for any additional collections agency charges along with the balance owed to Y Plastic and Reconstructive Surgery.

Patient or Responsible Party Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**In order to be thoroughly familiar with your individual needs, we request that you complete this form accurately. This is part of your Medical Record and is kept absolutely confidential!**

**Allergies:** (Latex, Lidocaine, Epinephrine, Medication) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had any reaction to injections of a local anesthesia or general anesthesia? Yes No**

Are you taking any of the following? (Please circle): Aspirin, Advil, Aleve, Ibuprofen, Motrin

Date of last physical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List previous surgeries you have had, dates, and attending Physician:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Have you had any type of implants? Yes No | What type? \_\_\_\_\_\_\_\_\_\_\_\_\_When? \_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you been on Accutane within the past 12 months? | Yes | No |

**General Health History:** Have you been or are you now under treatment for any of these major medical conditions? Pleasecircle Yes or No.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Anemia** | **Yes** | **No** | **High Blood Pressure** | **Yes** | **No** | **Psoriasis** | **Yes** | **No** |
| **Arthritis** | **Yes** | **No** | **HIV** | **Yes** | **No** | **Eczema** |  **Yes No** |
| **Autoimmune** | **Yes** | **No** | **Hives** | **Yes** | **No** | **Thyroid Disorder** | **Yes** |  **No** |
| **Lupus** | **Yes** | **No** | **Keloids/Scars** | **Yes** | **No** | **Endocrine DisorderYes No** |
| **Bleeding Disorders Yes** | **No** | **Migraines** | **Yes** | **No** | **Skin Diseases** |  **Yes No** |
| **Blood Clots** | **Yes** | **No** | **Pacemaker** | **Yes** | **No** | **Skin Cancer** |  **Yes No** |
| **Cancer** | **Yes** |  **No** | **Defibulator** | **Yes** | **No** | **Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Diabetes** | **Yes** | **No** | **Headaches** | **Yes** | **No** | **Sun Allergy** | **Yes** | **No** |
| **Eye Problems** | **Yes** | **No** | **Asthma** | **Yes** | **No** | **Neurological Disor. Yes** | **No** |
| **Hay Fever** | **Yes** | **No** | **Bronchitis** | **Yes** | **No** | **Seizures** |  **Yes No** |
| **Heart Arrhythmia Yes** | **No** | **Lung Disease** | **Yes** | **No** | **Kidney Disease** |  **Yes** | **No** |
| **Heart Murmur** | **Yes** | **No** | **Emphysema** | **Yes** | **No** | **UI-Tract Diseases** | **Yes** | **No** |
| **Heart Disease** | **Yes** | **No** | **Psychiatric Disorder** | **Yes** | **No** | **GI Disease** | **Yes No** |
| **Hepatitis** | **Yes** | **No** | **Recent Weight Gain/Loss Yes** | **No** | **History of Melanoma Yes No** |
| **Herpes/Cold Sores Yes** | **No** | **Rheumatic Fever** | **Yes** | **No** | **History of Atypical Moles Yes No** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Female:** | **Currently Pregnant: Yes** | **No Menstrual Irregularity: Yes** | **No Birth Control: Yes** | **No** |
| Do You Smoke? |  | Yes |  No |  | How much/often? \_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Do You Drink Alcohol? |  | Yes | No |  | How much/often? \_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Do You Drink Caffeine? |  | Yes | No |  | How much/often? \_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Recreational Drug Use/Diet Pills? | Yes | No |  | How much/often? \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Do You Exercise Regularly? | Yes | No |  | How much/often? \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Family History:** Have any members of your immediate family had treatment for any of the following? |  |
| Arthritis | Yes | No | Diabetes | Yes | No | Hay Fever | Yes | No |
| Asthma | Yes | No | Eczema | Yes | No | Psoriasis Yes | No |  |
| Cancer | Yes | No | Hair Loss | Yes | No | Skin Cancer | Yes | No |

Y Plastic and Reconstructive Surgery- Occasionally, it is necessary to have your picture taken, and sometimes more than one procedure may be necessary to achieve something similar to the results discussed. Therefore, be advised that this service is provided for the purpose of illustration only, and no guarantees are made to the specific outcome of any surgical procedure. Any such warranties, expressed or implied, are hereby waived by the patient and indemnifies and holds harmless the physicians/staff.

I authorize Y Plastic and Reconstructive Surgery to take my pre and post-op pictures

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date

Photograph Release Agreement

I authorize Y Plastic and Reconstructive Surgery to use my before and after photographs in the following instance:

(Please initial each line showing your permission).

1. \_\_\_ In a slide presentation or a case study at a conference or a seminar to the general public. (Patient Name Is Never Used)

2.\_\_\_ In publications or a book displayed in other professional offices or waiting areas.

(Patient Name is Never Used)

3.\_\_\_ I am willing to speak by telephone to other patients interested in plastic surgery.

(Patient Name is Never Used)

4.\_\_\_ I am willing to have my picture and/or video shown in any form of media, including television and internet. (Patient Name is Never Used)

5.\_\_\_ I am willing to have my picture shown on Y Plastic and Reconstructive Surgery

 website for educational purposes. (Patient Name is Never Used)

**Cancellation Policy**

Consultation- 48 hour cancellation notice, otherwise $100 fee

Cosmetic- 24 hour cancellation notice, otherwise $50 fee

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Y Plastic and Reconstructive Surgery may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare options (TPO). Please refer to

Y Plastic and Reconstructive Surgery’s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Y Plastic and Reconstructive Surgery reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Y Plastic and Reconstructive Surgery at 145 Towne Lake Parkway, Woodstock, GA 30188.

With my consent, Y Plastic and Reconstructive Surgery may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Y Plastic and Reconstructive Surgery may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Y Plastic and Reconstructive Surgery may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Y Plastic and Reconstructive Surgery restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With my consent, Y Plastic and Reconstructive Surgery may use any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examinations, testing, credentialing, and/or certifying purposes by the American Board of Plastic Surgery, Inc., and/or in advertisements, or for the express purpose of instructing and informing future patients.

By signing this form, I am consenting to Y Plastic and Reconstructive Surgery’s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Y Plastic and Reconstructive Surgery may decline to provide treatment to me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Guardian Patients Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient or Legal Guardian Date

**Review of Systems: In the past six months have you had any of the following: (Check all that apply)**

|  |  |
| --- | --- |
| **Mental Health (Psychological)** |  |
|  ( ) Depression/Anxiety ( ) Other \_\_\_\_\_\_\_\_\_\_\_ ( ) No Problem  |  | **Women’s Health (Gynecology)** ( )Hysterectomy |
|  |  | ( ) Last Menstrual Period |
|  |  | ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ( ) No Problems |
| **Urinary (Genitourinary)** |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ( ) Night awakening to urinate | **Skin (Integumentary)** |
| ( ) Bleeding/Discharge |  | ( ) Rashes |
| ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ( ) Itching |
| ( ) No Problems |  | ( ) Ulcers |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Head** |  | ( ) No Problems |
| ( ) Head Trauma |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ( ) Seizures |  | **Blood (Hematologic)** |
| ( ) Dizziness |  | ( ) Anemia |
| ( ) Stroke |  | ( ) Bleeding Problems |
| ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ( ) Sickle Cell Disease |
| ( ) No Problems |  | ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ( ) No Problems |
| **Nerve (Neurologic)** |  | **Do you take blood thinners?** Yes No |
| ( ) Loss of movement/control of limbs | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ( ) Tingling/ “Pins and Needles” | **Heart/ Circulatory (Cardiovascular)** |
| ( ) Loss of feeling in limbs |  | ( ) Heart Murmur |
| ( ) Loss of strength in limbs |  | ( ) Irregular Heartbeat/Pulse |
| ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ( ) Chest Pain |
| ( ) No Problems |  | ( ) High Blood Pressure |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ( ) Leg/Ankle Swelling |
| **Hormonal Problems (Endocrine)** | ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ( ) Thyroid Problems |  | ( ) No Problems |
| ( ) Diabetes |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Insulin Dependent: Yes | No | **Stomach (Gastrointestinal)** |
| ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ( ) Reflux |
| ( ) No Problems |  | ( ) Vomiting |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ( ) Constipation |
| **Breathing (Respiratory)** |  | ( ) Diarrhea |
| ( ) Shortness of Breath |  | ( ) Abdominal Pain |
| ( ) Asthma/Wheezing |  | ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ( ) Chronic Cough |  | ( ) No Problems |
| ( ) Previous Anesthesia Problems | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| ( ) No Problems |  |  |
|  |  |  |
|  |  |  |