PATIENT INFORMATION

Atlantic PLASTIC SURGERY

Referring Doctor _____ Primary Care Doctor _____

Patient's Name _____
Last First Middle

SS # _____ Birth Date _____ Age _____ Sex M F OTHER

Address _____ Home Phone# _____

City _____ Cell# _____

State _____ Zip _____ E-mail _____

How did you hear about our practice? _____

Patient employer _____ Work Phone# _____

Address _____ Occupation _____

City _____ State _____ Zip _____

If an injury occurred on job, list date: _____ Did you report the accident to your employer? Yes No

Worker's Comp Carrier _____ Phone # _____ Claim # _____

Address _____ City _____ State _____ Zip _____

Complete this section only if someone other than the patient is financially responsible OR if the primary card holder for the insurance is not the patient.

Responsible Party _____

SS # _____ Birth date _____ Relation _____

Address _____ Home Phone# _____

City _____ Cell Phone# _____

State _____ Zip _____ Work Phone# _____

Employer _____

Emergency Contact _____ Relation _____

Home Phone# _____ Cell Phone# _____

Assignment of Benefit: I hereby authorize my insurance company(s) to make payment(s) as stipulated in my policy for any services furnished and that such payment(s) be paid directly to the provider of the services. I also understand that I am financially responsible for all services provided and agree to pay upon demand or as agreed for the related charges or remaining charges following my insurance payment(s).

Permission for Treatment: I hereby authorize the physician and/or assistants for the care of the patient named on this record administer any treatment as may be deemed necessary including examinations or treatments that may be ordered to be performed by clinical personnel. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of examinations or treatments to be performed.

Permission for Release of Medical Information: I understand and agree that any of the above information may be used, if necessary, for the purpose of communication for appointment charges, accounts receivable, emergencies, etc. Information from my medical records may be released, if necessary, for insurance purposes.

Signature of Patient _____ Date _____

Signature of Parent/Guardian _____ Relationship _____ Date _____

106 MILFORD ST. SUITE307 | SALISBURY.MARYLAND 21804 | PH: 410-548-9555 FX:410-5489803
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HEALTH HISTORY

Patient: _____ SS# _____

Primary Care Doctor: _____

Referring Doctor: _____

Smoking: (type & amount per week) _____ Weight _____

Alcohol: (type & amount per week) _____ Height _____

If former smoker, date quit: _____ Hand Dominance R or L

Drug Allergies: _____

Previous surgeries or major illnesses and dates: _____

_____

List any medications you are taking, including non-prescription drugs, vitamins, and herbals: _____

_____

_____

Why are you here today? _____

_____

If this visit is due to an accident or injury, please give date of occurrence: _____

Family History: Has any blood relative ever had any of the following?

Breast Cancer	No	Yes	High blood pressure	No	Yes	Kidney disease	No	Yes
Skin Cancer	No	Yes	Heart Disease	No	Yes	Depression	No	Yes
Type _____			Diabetes	No	Yes	Stroke	No	Yes

Past Medical History: Have you ever had any of these?

Heart Disease	No	Yes	Cancer	No	Yes	Arthritis	No	Yes
Ulcer	No	Yes	Type: _____			Kidney Disease	No	Yes
High Blood Pressure	No	Yes	Anemia	No	Yes	Thyroid Disease	No	Yes
Asthma	No	Yes	AIDS or HIV positive	No	Yes	Bleeding tendency	No	Yes
Diabetes	No	Yes	Stroke	No	Yes	Mitral Valve Prolapse	No	Yes
Sleep Apnea	No	Yes	Hepatitis	No	Yes	Rheumatic fever	No	Yes
COPD	No	Yes	Glaucoma	No	Yes			
Cold Sores/Fever blister	No	Yes	Tuberculosis	No	Yes			

Review of Systems: Do you have now, or have you had within the past year?

Weight change	No	Yes	Swollen feet/ankle	No	Yes	Seizures	No	Yes
Dry eyes	No	Yes	Skin rash	No	Yes	Joint or muscle pain	No	Yes
Chronic cough	No	Yes	Chronic diarrhea	No	Yes	Swollen lymph nodes	No	Yes
Chest pain	No	Yes	Jaundice	No	Yes	Easy bleeding	No	Yes
Rapid heartbeat	No	Yes	Depression	No	Yes	Easy bruising	No	Yes

Women only:

Age period began _____ Did you breast feed No Yes

Number of pregnancies _____ Breast lump or discharge No Yes

Date of last mammogram _____ Do you do regular breast self-examination No Yes

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

Signature of Patient _____ Date _____

Signature of Parent/Guardian _____ Date _____

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EMERGENCY CONTACT INFORMATION

Emergency Contact: _____

Relationship to patient: _____

Phone# _____

Would you like the Emergency Contact to be given access to your medical information?

Yes☐

No☐

How do you prefer to be contacted regarding your appointments?

Home Phone☐

Cell Phone☐

Email☐

Please list your retail Pharmacy:

Name: _____

Address: _____

_____

Phone#: _____

_____Date: _____

Signature of Patient

_____Date: _____

Signature of Parent/ Guardian

ATLANTIC PLASTIC SURGERY

Notice to Patients of Privacy Practices

This notice describes how medical information about you may be used and disclosed. We are required by law to protect the privacy of your protected health information. This document also explains how you can gain access to your medical information and whom to contact should you have any complaints.

Please read this document carefully and sign the form to acknowledge you have received this notice.

A The general consent for release of medical records you sign authorizes Atlantic Plastic Surgery to disclose the information in your medical record for treatment, payment, and health care operations:

1. For the purpose of providing, coordinating, or managing your treatment and related services. Your information may be shared with employees and contractors of the provider, or with other health care providers who are treating you or consulting in your care.

2. For the purpose of arranging payment for your care. Your information may be shared with your insurer or other third party who is responsible for paying all or part of the cost for your care. This may include certain activities your health insurance plan or workers compensation insurer requires before it approves or pays for health care services we recommend.

3. For the purpose of health care operations. We may use and disclose information that is necessary for our business operations, e.g., internal quality assessments or contacting other health care providers about treatment alternatives. We may use information about you to remind you by telephone, letter or postcard of an appointment for treatment of medical care or to notify you of a diagnostic test result.

B. You may be asked to sign a specific authorization for release of medical records, which will authorize us to make a specific disclosure that is not covered under section A above. The specific information, the entity to whom it will be disclosed, and the purpose for which it will be used will be documented for your review before signing.

C. You may revoke any consent or authorization provided to us by giving a written notice of revocation.

D. We may be required by law to disclose your records that you have not authorized. Examples of these situations include, but are not limited to, complying with workers compensation laws, receiving a subpoena for the records, or if public responsibility requires disclosure to protect public health. We will keep any disclosures of your medical records to the minimum necessary.

E. Your rights regarding health information about you:

1. You have the right to inspect a copy of your health information.

2. If you feel that the health information, we have about you is incomplete or inaccurate, you have the right to request an amendment to your medical records. The request must be made in writing with the reason that supports your request. If we do not agree with your request, you have the right to ask that your statement be placed in the medical record.

3. You have the right to find out how your health information is used and to whom it is disclosed. You may request an accounting of your medical record disclosures made by us except for disclosures made for treatment, payment, and health care operations covered in Section A.

F. We are required by law to maintain the privacy of your protected health information and if you believe that your rights have been violated, you may complain to the Secretary of the U.S. Department of Health and Human Services or complain to us in person, over the phone, or in writing. Please contact our privacy complaints contact person, Jobie Burke, at our office. We will not retaliate in any way against a patient for making a complaint.

G. We reserve the right to change our privacy practices and to make new policies effective for all protected health information that we maintain. If we should do so, we will issue an updated "notice to patients" to all our patients.

Signature: _____ Date: _____