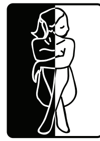
(Please Print)

PATIENT INFORMATION



Savannah Plastic Surgery

Date________________________

Doctor________________________

7208 Hodgson Memorial Dr. | Savannah, GA 31406 | www.SavannahPlasticSurgery.com

Patient's Name:	Date of Birth	Age	Sex

Social Security No.	Email Address	Home Phone No. ( )

Street Address ❑ Permanent ❑ Temporary	City and State	Zip Code	Business Phone No. ( )

Patient's Employer	Occupation	How Long Emp.?	Cell Phone No. ( )

Employer's Street Address	City and State	Zip Code

Primary Care Physician	PCP Phone #	How did you hear about us?

Please check all that apply: *(These questions are required by the Federal Government to meet Meaningful Use Guidelines - you may decline to answer by checking DECLINED in each column.)*

Marital Status:
- ❑ Married
- ❑ Single
- ❑ Divorced
- ❑ Separated
- ❑ Widowed
- ❑ Declined

Race:
- ❑ American Indian/Alaska Native
- ❑ Asian
- ❑ Black/African American
- ❑ Native Hawaiian/Pacific Islander
- ❑ White
- ❑ Other:______________________
- ❑ Declined

Ethnicity:
- ❑ Hispanic/Latino
- ❑ Not Hispanic/Latino
- ❑ Declined

***Sexual Orientation**
- ❑ Straight/Heterosexual
- ❑ Lesbian/Gay/Homosexual
- ❑ Bisexual
- ❑ Don't Know
- ❑ Choose not to disclose

State Regulations Require us to include these questions, you do not have to answer.

Religion:
- ❑ Buddhist
- ❑ Catholic
- ❑ Hindu
- ❑ Islam
- ❑ Jehovah's Witness
- ❑ Jewish
- ❑ Mormon
- ❑ Protestant
- ❑ Other:________ ________________
- ❑ Declined

Spouse's Name	Spouse's Date of Birth	Spouse's Social Security No.

Spouse's Employer	Employer's Street Address	City and State	Zip Code

Spouse's Occupation	How Long Emp.?	Spouse's Business Phone No. ( )

In Case of Emergency Contact (Not living with you)	Relationship	Home Phone ( )	Business Phone ( )

Contact's Street Address	City and State	Zip Code

IF THE PATIENT IS A MINOR OR STUDENT

Mother's Name	Date of Birth	Social Security No.	Home Phone No. ( )

Street Address, City, Sate and Zip Code	Mother's Employer	Occupation

Employer's Street Address, City, State and Zip Code	Business Phone ( )

Father's Name	Date of Birth	Social Security No.	Home Phone No. ( )

Street Address, City, Sate and Zip Code	Father's Employer	Occupation

Employer's Street Address, City, State and Zip Code	Business Phone ( )

Name ________________________________

PATIENT HISTORY

Chief Complaint: For what reason are you seeing the doctor today? ____

____

PAST MEDICAL HISTORY

Ht. _________ Wt. ________

Have you ever had a problem with bleeding or blood clotting? .... ☐ Yes ☐ No

Have you had or presently have any of the following? (check)

❑ Aids or tested HIV positive
❑ Diabetes
❑ Cancer
❑ Tuberculosis
❑ Pneumonia
❑ Epilepsy
❑ Hepatitis (Type: ❑ A ❑ B ❑ C)
❑ Anemia
❑ Heart Disease
❑ Lung Disease
❑ Muscle Disease
❑ Nervous Conditions
❑ Kidney Disease
❑ Liver Disease
❑ Skin Cancer
❑ Mental Illness
❑ Heart Murmur
❑ Irregular Heart Beats
❑ High Blood Pressure
❑ Bleeding Tendencies
❑ Stomach/Intestinal Disease
❑ Rheumatic Fever
❑ Cancer of Breast
❑ Heart Attack
❑ Stroke
❑ Thyroid Disease

Last tetanus__________________

Are you pregnant? ____ Date of last mammogram ________________________________

List any childhood illnesses you have had: ____

Children - Are immunizations current? ____

List any serious injuries you have received and when they occured: ____

____

Previous hospitalizations/surgeries:

Reason: Date: Location:

1.____
2.____
3.____
4.____
5.____

GYN: Date of last menstrual period:_____________________ Are your periods regular? YES / NO

Number of births:__________________ Number of pregnancies:_________________ Number of miscarriages:_____________________

Medications: please list all prescriptions/vitamins/birth control/over the counter/herbal supplements, their dosage and how many times you take per day.

____
____
____
____
____

Drug Allergies: please include the name of the medication and reaction.

____
____
____

Food Allergies: please list any food allergies.

____

FAMILY HISTORY

	Age	Living	Dead	Cause of Death	Major Diseases
Father					
Mother					
Sisters					
Brothers					

Check any illnesses that have affected any close relatives (parents, siblings):

❑ Cancer
❑ Heart Attacks
❑ Strokes
❑ Diabetes
❑ Hemophilia
❑ Heart Disease
❑ Rheumatic Fever
❑ Sickle Cell Anemia
❑ Bleeding Tendencies
❑ High Blood Pressure
❑ Brain Hemorrhage
❑ Breast Cancer
❑ Others____________________
____
____

SOCIAL HISTORY

Do you live alone? ______________________________ Occupation: ____

Habits: Smoking: ☐ Yes ☐ No ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Other

How much? ____________________________

Former Smoker? _____________ When did you stop? _______________ How Long?

Alcohol: ☐ None ☐ Occasionally ☐ Frequently How much? _________________

Please answer the following regarding your health:

1. Have you had recent fevers or chills? .... ☐ Yes ☐ No
2. Have you had a significant change in weight? .... ☐ Yes ☐ No

   Increase or Decrease (circle one) How much? __________

3. Do you have tearing, dry eyes, wear contacts or glasses? (circle one).. ☐ Yes ☐ No
4. Do you have problems with your hearing, sore throats, congested sinus or snoring? (circle one) .... ☐ Yes ☐ No
5. Do you get tightness, pressure, or squeezing in your chest? .... ☐ Yes ☐ No
6. Are you under treatment for high blood pressure? .... ☐ Yes ☐ No
7. Do you frequently suffer from chest colds, chronic coughing,

   bronchitis, asthma or difficulty breathing? (circle one) .... ☐ Yes ☐ No

8. Have you had diarrhea, nausea or vomiting? (circle one) .... ☐ Yes ☐ No
9. Have you had a recent change in bowel habits? .... ☐ Yes ☐ No
10. Do you have burning with urination? .... ☐ Yes ☐ No
11. Do you have pain in the joints, muscle aches or spasms? .... ☐ Yes ☐ No

    Where? _______________________________________

12. Have you noticed a change in a mole or skin lesion? .... ☐ Yes ☐ No

    Describe _______________________________________

    (size, color, shape, itching or bleeding)

13. Have you had excessive exposure to the sun or a tanning bed? .... ☐ Yes ☐ No
14. Have you had or do you have a breast lump? .... ☐ Yes ☐ No
15. Do you perform a regular breast self-examination? .... ☐ Yes ☐ No
16. Are you under treatment for depression? .... ☐ Yes ☐ No
17. Have you ever had a blood transfusion before?....................... When?________________________ ☐ Yes ☐ No
18. Have you ever had a blood transfusion reaction?.....................When?________________________ ☐ Yes ☐ No
19. Has anyone in your family had bleeding tendencies or hemophilia?.. ☐ Yes ☐ No

Please list any additional information you feel is pertinent to your care: ____

____

____

SIGNATURE ____ Date __________________________

PAYMENT POLICY AND ASSIGNMENT OF BENEFITS

All services rendered by the physicians in this office are on a fee for service basis. Deductibles and coinsurance obligations associated with your chosen plan are your responsibility. These will be collected at the time of service for office visits. For cosmetic surgery or other scheduled procedures, these will be collected at least three weeks prior to the procedure/surgery.

We have customarily waited up to 45 days for payment from insurance companies. If your insurance company has not reimbursed us for serves rendered within 45 days from the date filed, we ask that you make arrangements to pay your balance with this office.

If any portion of your surgery is deemed medically necessary by the physician, it will be submitted to the insurance company we have on file. A deposit might be required prior to the surgery/procedure. Please verify we have the most updated insurance information on file.

I hereby authorize and assign payment directly to the rendering physician at Savannah Plastic Surgery or Savannah Plastic Surgicenter, any medical or surgical benefits that the professional corporation may be entitled to under my medical-surgical plan.

I understand that I am responsible for any balance due for professional services in excess of the benefits provided by my policy. I understand that if my insurance plan does not make payment within 45 days I will begin making monthly payments on the balance due.

I hereby agree that in the event of default in payment of any amount due and if this account is placed in the hands of a collection agency or attorney, I will pay an additional charge equal to the cost of collection agency fee, attorney's fee and court cost incurred and permitted by laws covering these transactions.

Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are rendered.

______________________________ RESPONSIBLE PARTY'S SIGNATURE

______________________________ PATIENT'S SIGNATURE

______________________________ DATE SIGNED

______________________________ WITNESSED BY

If your services are covered by Workman's Compensation or an Attorney is handling your injury case it is imperative that you notify the receptionist prior to being seen. Please indicate the name, address and phone number of your representing Attorney if the above statement applies:

________________	________________	________________
Attorney's Name	Attorney's Address	Attorney's Phone #

Due to the multitude of changes in many of the different insurance plans, it is required for our patients to provide the following information listed below at all times. This will not only expedite but also comply with your specific carrier requirements. IT IS UP TO THE PATIENT TO KNOW WHICH HOSPITAL AND LAB YOUR INSURANCE COMPANY REQUIRES YOU TO USE.

Our office requires that you bring your insurance card and co-payment to every visit. If you do not bring your insurance card, you will be considered self pay and be responsible for your charges. Payment will be expected in full on the date of service.

Insurance Company Name ____

Referral required from Primary Care Doctor? ____Yes ____No

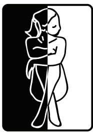
My lab must be sent to __________________ Laboratory.

My insurance company requires me to go to ___________________ Hospital.

I UNDERSTAND THAT PRECERTIFICATION OF SERVICES IS NOT A GUARANTEE OF PAYMENT. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ALL RELATED EXPENSES.

______________________________ Signature

______________________________ Date



Savannah
Plastic Surgery

AUTHORIZATION TO RELEASE INFORMATION

Name ____
(last) (first) (initial)

Address ____
(street) (city) (state)

Phone (________)______________________ Date of Birth ___________________ Medical Record #________________________

I authorize ____to release medical information from my medical record to:

Name of Doctor, Hospital, etc. ____

Address ____

City/State/Zip Code ____

for the purpose of review/examination, I further authorize you to provide such copies thereof as may be requested .

The foregoing is subject to such limitation as indicated below:

- ❑ Entire record
- ❑ Specific information: ____
- ❑ Old records from previous physicians: ____

I give special permission to release any information regarding: (initial on applicable line(s) below)

______________Substance Abuse _______Psychiatric/Mental Health information _______HIV information

Reason for request ____
This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon,

Signed ____I)ate ______________________
(if not patient, state relationship)

Witness ____Date ______________________

FOR OFFICE USE ONLY

Received______________________________Completed B ______________________________

Completed_ ______________________________Fee Paid______________________________

Amount Billed $ ______________________________Amount Due ______________________________

Disclosure Consisted Of ____

____

____

Savannah Plastic Surgery
7208 Hodgson Memorial Dr.
Savannah, Georgia 31406
(912) 351-5050 Phone
(912) 351-5051 Fax

HIPAA DISCLOSURE FORM
Authorization for release of information for specific purposes.

I hereby authorize Savannah Plastic Surgery to release the following information from the health records of:

Patient Name:____ Date of Birth:____________________________

To be released to:

Name:______________________ Relationship:________________ DOB:_______________ Phone:_____________________

Name:______________________ Relationship:________________ DOB:_______________ Phone:_____________________

INFORMATION TO BE RELEASED: (Check All That Apply)

❏ Entire record	❏ Lab results	❏ Demographics
❏ Radiology results	❏ Medication records	❏ Office notes

FOR THE PURPOSE OF:

❏ Anything on behalf of patient	❏ Creating/changing appointments	❏ Picking up prescriptions, forms, medications
❏ Speaking to SPS Staff regarding my PHI	❏ Billing purposes	❏ Other:______________________

I understand that Savannah Plastic Surgery will refuse to discuss my information with anyone not listed above, except in an emergency. I understand that I can revoke this authorization by providing written notice to Savannah Plastic Surgery at the address listed above. I understand that if information has been released by relying upon this authorization, that revocation will not be valid. I place no limitations on history of illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse or dependency, psychiatric or psychological illness, mental illness or retardation and acquired immune deficiency (AIDS) syndrome, I understand that I am waiving my rights to privacy by releasing my medical information to the above listed parties and this information may be re-disclosed by the receiving party. I hereby authorize the entity listed above to release the said information described above. I also understand that his consent does not apply to medical providers in the treatment of my care.

In addition to granting permission to the above named individuals, I have received a copy of the Savannah Plastic Surgery "Notice of Privacy Practices" which details how my personal health information may be used and disclosed as permitted under Federal and State law. I have read and understand the contents of the notice. *This form can be amended at any time if the patient/responsible party completes and signs a new form.*

____ ______________________________

Print Patient's Name | Date

____ ______________________________

Signature of Patient or Responsible Party | Witness