PLASTIC, RECONSTRUCTIVE, *and* HAND SURGERY

3330 Preston Ridge Rd. Suite 340 Alpharetta, GA 30005 P: (404) 822-4402 F: (888) 214-4416

PATIENT REGISTRATION DATE _____

NAME AGE DATE OF BIRTH

ADDRESS E-MAIL ADDRESS

CITY STATE ZIP SSN#

PHONE (HOME) (CELL) (WORK) OCCUPATION/EMPLOYER

SPOUSE'S NAME(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	( ) Breast	( ) Botox
( ) Eyelid	( ) Breast Augmentation	( ) Hand	( ) Injectable
( ) Nose	( ) Body Lift	( ) Scar Revision	( ) Doctor Visit
( ) Chin/Cheeks	( ) Gluteal Augmentation	( ) Moles, etc.	( ) Thermi Tx
( ) Ear Reshaping	( ) Liposuction	( ) Wounds	( ) Other
( ) Tuck Up	( ) Vaginal Rejuvenation		

REFERRED BY:

* Doctor (name _____)
* Friend (name _____)
* Family (name _____)
* Print Ad _____
* Online, website: _____

PHARMACY NAME AND NUMBER _____

INSURANCE BENEFITS

PRIMARY

Insurance Company _____
Name of Policy Holder _____
Policy Holder's Date of Birth _____
Relationship of Patient to Policy Holder _____
Policy Holder Telephone Number _____

SECONDARY

*Insurance Company*_____
Name of Policy Holder _____

Relationship of Patient to Policy Holder _____
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: _____/_____/_____

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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? Please circle 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 Disorder**	**Yes**	**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**	**Urinary Infection**	**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**	**Atypical Moles**	**Yes**	**No**
Birth Control	**Yes**	**No**	**Menstrual Irregularity**	**Yes**	**No**	**Currently Pregnant**	**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

Patient or Responsible Party Signature _____ Date ___/___/___

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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)

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Cancellation Policy

Consultation- 48 hour cancellation notice, otherwise $100 fee

Surgery- 1 week cancellation notice, otherwise $500 fee

_____ _____

Patient Date

_____ _____

Witness Date

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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).

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 communicate through text messages sent through an automatic telephone dialing system. These automated text messages can include special promotions, information about new services or team members, as well as allow me to request an appointment. I understand that I will always have the ability to opt-out if I decide that I no longer want to receive texts from this practice.

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

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Mental Health (Psychological)

( ) Depression/Anxiety

( ) Other _____

( ) No Complications

Women's Health (Gynecology)

( ) Hysterectomy

( ) Last Menstrual Period

( ) Other _____

( ) No Complications

Urinary (Genitourinary)

( ) Night awakening to urinate

( ) Bleeding/Discharge

( ) Other

( ) No Complications

Skin (Integumentary)

( ) Rashes ( ) Other _____

( ) Itching ( ) No Complications

( ) Ulcers

Head

( ) Head Trauma ( ) Other _____

( ) Seizures ( ) No Complications

( ) Dizziness

( ) Stroke

Blood (Hematology)

( ) Anemia

( ) Sickle Cell Disease

( ) Other

( ) No Complications

Nerve (Neurologic)

( ) Loss of movement/ control of limbs

( ) Tingling

( ) Loss of feeling in limbs

( ) Other

( ) No Complications

Heart/ Circulatory (Cardiovascular)

( ) Heart Murmur ( ) Other _____

( ) Irregular Heartbeat/Pulse ( ) No Complications

( ) Chest Pain

( ) High Blood Pressure

( ) Leg/Ankle Swelling

Hormonal (Endocrine)

( ) Thyroid Issues

( ) Diabetes , Insulin Dependent: YES NO

( ) Other

( ) No Complications

Stomach (Gastrointestinal)

( ) Reflux ( ) Other _____

( ) Vomiting ( ) No Complications

( ) Constipation

( ) Diarrhea

( ) Abdominal Pain

Breathing (Respiratory)

( ) Shortness of Breath ( ) Other _____

( ) Asthma/ Wheezing ( ) No Complications

( ) Chronic Cough

( ) History of Anesthesia