



**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
<input type="checkbox"/> Facelift	<input type="checkbox"/> Tummy Tuck	<input type="checkbox"/> Breast	<input type="checkbox"/> Botox
<input type="checkbox"/> Eyelid	<input type="checkbox"/> Breast Augmentation	<input type="checkbox"/> Hand	<input type="checkbox"/> Injectable
<input type="checkbox"/> Nose	<input type="checkbox"/> Body Lift	<input type="checkbox"/> Scar Revision	<input type="checkbox"/> Doctor Visit
<input type="checkbox"/> Chin/Cheeks	<input type="checkbox"/> Gluteal Augmentation	<input type="checkbox"/> Moles, etc.	<input type="checkbox"/> Thermi Tx
<input type="checkbox"/> Ear Reshaping	<input type="checkbox"/> Liposuction	<input type="checkbox"/> Wounds	<input type="checkbox"/> Other
<input type="checkbox"/> Tuck Up	<input type="checkbox"/> Vaginal Rejuvenation		
REFERRED BY:			
* Doctor (name _____)		* Print Ad _____	
* Friend (name _____)		* Online, website: _____	
* Family (name _____)			
PHARMACY NAME AND NUMBER _____			
INSURANCE BENEFITS			
<u>PRIMARY</u>		<u>SECONDARY</u>	
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: ____/____/____



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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

Y Plastic Surgery adheres to a 24-hour cancellation policy. Please call us at 404-822-4402 if you need to reschedule or cancel your appointment. Failure to show and any cancellations with less than 24 hours of notice are subject to a cancellation fee amounting to the cost of the scheduled service.

There is a non-refundable administrative cancellation fee of \$500 if you decide to cancel your procedure or surgery once your date has been secured and payment is accepted in our office.

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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<u>Mental Health (Psychological)</u> <input type="checkbox"/> Depression/Anxiety <input type="checkbox"/> Other _____ <input type="checkbox"/> No Complications	<u>Women's Health (Gynecology)</u> <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Last Menstrual Period <input type="checkbox"/> Other _____ <input type="checkbox"/> No Complications
<u>Urinary (Genitourinary)</u> <input type="checkbox"/> Night awakening to urinate <input type="checkbox"/> Bleeding/Discharge <input type="checkbox"/> Other <input type="checkbox"/> No Complications	<u>Skin (Integumentary)</u> <input type="checkbox"/> Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Ulcers <input type="checkbox"/> Other _____ <input type="checkbox"/> No Complications
<u>Head</u> <input type="checkbox"/> Head Trauma <input type="checkbox"/> Seizures <input type="checkbox"/> Dizziness <input type="checkbox"/> Stroke <input type="checkbox"/> Other _____ <input type="checkbox"/> No Complications	<u>Blood (Hematology)</u> <input type="checkbox"/> Anemia <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Other <input type="checkbox"/> No Complications
<u>Nerve (Neurologic)</u> <input type="checkbox"/> Loss of movement/ control of limbs <input type="checkbox"/> Tingling <input type="checkbox"/> Loss of feeling in limbs <input type="checkbox"/> Other <input type="checkbox"/> No Complications	<u>Heart/ Circulatory (Cardiovascular)</u> <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Irregular Heartbeat/Pulse <input type="checkbox"/> Chest Pain <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Leg/Ankle Swelling <input type="checkbox"/> Other _____ <input type="checkbox"/> No Complications
<u>Hormonal (Endocrine)</u> <input type="checkbox"/> Thyroid Issues <input type="checkbox"/> Diabetes , Insulin Dependent: YES NO <input type="checkbox"/> Other <input type="checkbox"/> No Complications	<u>Stomach (Gastrointestinal)</u> <input type="checkbox"/> Reflux <input type="checkbox"/> Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Other _____ <input type="checkbox"/> No Complications
<u>Breathing (Respiratory)</u> <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Asthma/ Wheezing <input type="checkbox"/> Chronic Cough <input type="checkbox"/> History of Anesthesia <input type="checkbox"/> Other _____ <input type="checkbox"/> No Complications	