FRISCO PLASTIC SURGERY, P.A.

(972) 334-0400

Patient Information

Fill in or correct all fields

Patient's Name ______________________________
First Middle Last

Address ______________________________
Street & Apt # City State Zip

Home Phone ____________ Cell Phone ____________ Other Phone ____________

Any restrictions for contacting you? No Yes If yes, contact restrictions: ____________

Email: ____________ Drivers License # and State ____________

Age ______ Birthdate ____________ Gender Female Male

Marital Status: Single Married to: ____________ Other: ____________

Patient's Employer ____________ Occupation ____________

Work Phone ____________ Ext: ______ Is it okay to call you at work? Yes No

Address ______________________________
Street & Suite # City State Zip

Responsible Party (if different from patient):

Name of spouse or parent if Patient is a minor ____________ Relationship to Patient ____________

Address ____________ Home Phone ____________

Emergency Contact
(Not in your household) ____________ Relationship to Patient ____________

Home Phone ____________ Cell Phone ____________ Other Phone ____________

Reason for today's visit ______________________________

How did you hear about Dr. Smart?

Frisco Style | Plano Profile | McKinney Woman | Southern Vanity | D Beauty
TV News | Salon | Facebook | www.kensmartmd.com | Other:____________

Friend/Relative: ____________ Doctor: ____________

Acknowledgement of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

Payment Policy: Payment is due in full at the time services are rendered.

Assignment of Benefits: I hereby assign all medical and/or surgical benefits to which I am entitled, including private insurance and any other health plans, to Frisco Plastic Surgery, P.A.. I transfer my title of reimbursement from my insurance company to Dr. Smart of Frisco Plastic Surgery, P.A.. I authorize Dr. Smart to bill my insurance company for medically necessary services. I authorize my insurance claim form to be sent via electronic filing. I authorize said assignee to release all information necessary to secure payment. I authorize the release of my medical records or insurance claims to be sent via fax. **Regardless of insurance coverage, I am responsible to pay any and all charges that exceed or that are not covered by insurance.** This assignment will remin in effect until revoked by me in writing. A photocopy of this assignement is to be considered as valid as an original.

Signature ______________________________ **Date** ____________

FRISCO PLASTIC SURGERY, P.A.

(972) 334-0400

6898 Lebanon Rd. Suite 102 , Frisco, TX 75034

Health Information as of _______________ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient:			
DOB	Age	Marital Status	Weight lbs
What surgery are you considering?			Height ft in

DO YOU NOW OR HAVE YOU EVER HAD……….. (You must circle an answer for each individual item)

Heart Trouble	Yes	No	Glaucoma or Eye Problems	Yes	No
Heart Attack	Yes	No	Visual Disturbances	Yes	No
Heart Pain	Yes	No	Error in Refraction	Yes	No
Palpitation or Irregular Pulse	Yes	No	Other Eye Problems	Yes	No
Extra Heart Beats	Yes	No	Hepatitis	Yes	No
Stroke	Yes	No	Yellow Jaundice	Yes	No
Hypertension	Yes	No	Gallstones or Gallbladder Trouble	Yes	No
Blood Pressure Abnormalities	Yes	No	Cirrhosis of the Liver	Yes	No
Abnormal EKG	Yes	No	Alcoholism or Drug Dependency	Yes	No
Rheumatic Fever	Yes	No	Esophageal Varices	Yes	No
Dropsy or Heart Failure	Yes	No	Frequent Indigestion	Yes	No
Digitalis Treatment	Yes	No	Ulcers	Yes	No
Shortness of Breath	Yes	No	Gastritis	Yes	No
Chest Pain	Yes	No	Colitis	Yes	No
Asthma	Yes	No	Problem Constipation	Yes	No
Bronchitis	Yes	No	Vomiting Blood	Yes	No
Pneumonia	Yes	No	Tarry or Bloody Bowel Movements	Yes	No
Tuberculosis	Yes	No	Hemorrhoids	Yes	No
Smokers Cough	Yes	No	Goiter or Thyroid Disorders	Yes	No
Emphysema	Yes	No	Diabetes	Yes	No
Coughing or Spitting of Blood	Yes	No	Skin Disorders	Yes	No
Hay Fever	Yes	No	Arthritis	Yes	No
Major Allergies	Yes	No	Fracture of Neck or Spine	Yes	No
Palsy or Paralysis	Yes	No	Bleeding Tendency or Disorder	Yes	No
Nervous Breakdown	Yes	No	Abnormal Bleeding after Tooth Extraction	Yes	No
Nervous Disorder	Yes	No	Airway Obstruction (Nasal)	Yes	No
Insomnia	Yes	No	Breast Cysts, Tumors, Abscesses	Yes	No
Drug Habit	Yes	No	Nipple Discharge (Apart from Normal Lactation)	Yes	No
Self-Destructive Tendencies	Yes	No	Kidney Disorder	Yes	No
Psychiatric Hospitalization or Care	Yes	No	Blood Transfusion	Yes	No
Thyroid Problems	Yes	No	Seizures or convulsions or fainting spells	Yes	No
Kidney or Renal Disease	Yes	No	Black outs	Yes	No
Heart murmur	Yes	No	Dentures, bridges, capped teeth or crowns	Yes	No
Piercing other than the ears	Yes	No	Loose teeth	Yes	No
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No	Cosmetic bonding to teeth	Yes	No
Missed or irregular last menstrual period	Yes	No	Any family members with bleeding problems	Yes	No
Family history of cancer, heart trouble, stroke	Yes	No	Any family members with anesthesia problems	Yes	No

1. **Please list all present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. **Include over-the-counter medications.**

   ____

   ____

2. Do you have an allergic reaction to any medication? ❒ Yes ❒ No Which? ______________________

3. Do you react abnormally to any medication? ❐ Yes ❐ No Which? ______________________________

4. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?

   ❐ Yes ❐ No If yes, when and where? ______________________________

5. Have you ever been on cortisone or steroid treatment? ❐ Yes ❐ No When? ______________________________

6. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?

   ❐ Yes ❐ No If so, how much? ______________________________

7. Do you smoke? ❐ Yes ❐ No If so, how much? ______________ For how long? ______________________

8. Are you pregnant? ❐ Yes ❐ No When was you last normal menstrual period? ______________________________

9. How many pregnancies? ________ Births? ________ Breast Fed? ❐ Yes ❐ No How long? ________________

   CHILDREN (list names and ages/birthdays): ______________________________

   ____

10. When was your last physical exam? ________________ By whom? ______________________________

11. When was your last eye examination? ______________ By whom? ______________________________

12. When and where was your last chest x-ray? ________________ EKG? ______________________________

13. Who is your personal physician, if any? ________________________Please list all physicians presently caring for you.

    ____

14. Have you ever been under psychiatric care? ❐ Yes ❐ No When? ______________Why? ____________________

15. Have you had any recent blood work done? ❐ Yes ❐ No Where? ______________________________

16. Is there anything else you think the doctor should know? ______________________________

    ____

17. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:

    SURGICAL OPERATIONS (include where, when and why for each surgery): ______________________________

    ____

    ____

    ____

    HOSPITALIZATIONS (include where, when and why for each admission): ______________________________

    ____

    ____

By signing below, I agreee that the above information is complete and accurate to the best of my knowledge.

Signature: ______________________________________ Date: ______________________

Frisco Plastic Surgery, P.A.

(972) 334-0400

Insurance Information & Authorization

(Please Print Legibly & Sign)

Patient's Name ______________________________
First Middle Last

Primary Insurance Company ______________________________

Insurance Phone Number: ______________________________

Claim's Address: ______________________________

Policy Number : ____________________ Group Number : ____________________

Policyholder's Information:

Name ______________________________ Birthdate / /

Employer ____________________ Relationship to Patient ____________________

Does this insurance required a referral? ❒ Yes ❒ No Copay Amount $ __________

Secondary Insurance Company ______________________________

Insurance Phone Number: ______________________________

Claim's Address: ______________________________

Policy Number : ____________________ Group Number : ____________________

Policyholder's Information:

Name ______________________________ Birthdate / /

Employer ____________________ Relationship to Patient ____________________

Does this insurance required a referral? ❒ Yes ❒ No Copay Amount $ __________

Is this visit due to any type of accident? ❒ No ❒ Yes: Date of Accident ____________________

All Insurance Patients

I request that payment of authorized benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services.

Beneficiary Signature ______________________________ Date __________

Medicare Patients Only

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature ______________________________ Date __________