Genesis
PLASTIC SURGERY

PATIENT INFORMATION: **(Please Print)**

*PATIENT'S FULL LEGAL NAME:*_____

SOCIAL SECURITY # _____-_____-_____ BIRTHDATE:_____/_____/_____ AGE_____ MALE____ FEMALE____

*ADDRESS:*_____ *CITY:*_____*ST:*_____ *ZIP:*_____

*PHONE NUMBER(s)*please star the number you prefer that we use**

HOME:(_____)_____-_____ CELL:(_____)_____-_____ OTHER:(_____)_____-_____

MARITAL STATUS: MARRIED____ DIVORCED____ SINGLE____ WIDOWED____

*PATIENT'S EMPLOYER:*_____ *OCCUPATION:*_____

*ADDRESS:*_____ *PHONE:(_____)_____-_____*

*EMERGENCY CONTACT:*_____ *RELATIONSHIP TO PATIENT:*_____

*ADDRESS:*_____ *PHONE:(_____)_____-_____*

*EMPLOYER:*_____ *PHONE:(_____)_____-_____*

PATIENTS E-MAIL: _____@_____

HOW DID YOU SELECT DR. THOMPSON? REFERED BY DOCTOR: _____

PATIENT_____ PHONEBOOK_____ INTERNET_____ INSURANCE BOOK_____ FRIEND_____ NEWSPAPER AD_____

MEDICAL HISTORY:

*REASON FOR CONSULTATION:*_____

*PRESENT SKIN CARE REGIMEN:*_____ *VITAMIN SUPPLEMENTS:*_____

*PLEASE LIST CURRENT MEDICATIONS:*_____

_____

*SMOKING HISTORY:*_____*IS THERE A PERSONAL HISTORY OF SERIOUS ILLNESS?:*_____

Check any of the following if applicable: *____ I have had a major surgery in the last month. ____ I have continuously swollen legs.*

____ I have had previous DVT (blood clot in the leg) or stroke. ____ I have family members who have had a DVT.

____ I am using oral birth control pills and/or hormone replacements.

____***Check here if none of the above applies to you.***

____***Check here if you or a family member has had any of the following:*** *unexpected death following a general anesthetic or exercise; malignant hyperthermia; a muscle or neuromuscular disorder; high temperature following exercise; a personal history of muscle spasm , dark urine or high fever immediately following anesthesia or intense exercise .*

DO YOU HAVE ANY ALLERGIES TO MEDICINE (INCLUDING ALLERGIES TO LATEX OR TAPE/ADHESIVES)?

*IF YES, PLEASE LIST*_____

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- I consent to pre-op and post-op images deemed necessary for accurate record keeping and authorize their use for professional purposes, including medical or patient education, as long as my identity is not disclosed.
- A consultation fee is due at the time of visit for new consults.

DATE: _____ SIGNATURE: _____

MEDICAL INSURANCE INFORMATION (PLEASE SHOW INSURANCE CARD TO RECEPTIONIST)

SKIP THIS SECTION FOR COSMETIC CONSULTATIONS

*PRIMARY INSURANCE CARRIER:*_____ *POLICY #:*_____

POLICY HOLDER: _____ *RELATIONSHIP TO PATIENT:* _____ *BIRTHDATE:*____/____/____

*POLICYHOLDER'S SOCIAL SECURITY #:*_____-____-_____ *EMPLOYER:*_____

STATEMENT OF PERMIT FOR RELEASE OF MEDICAL INFORMATION FOR PAYMENT OF INSURANCE BENEFITS CONSENT TO Genesis Plastic Surgery, P.C.

Patient's Full Name: _____

- I authorize release of medical information to my insurance if required for insurance benefits.
- I authorize the payment of authorized benefits to be made in my behalf and I assign payment directly to Genesis Plastic Surgery, P.C.
- I understand that I am responsible for any of the remaining insurance deductibles and any charges not covered by insurance.

Date: _____ Patient or Responsible Party's Signature: _____

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MEDICARE PATIENTS- Please sign this Medicare consent form.

LIFETIME CONSENT

- I request that payment of authorized Medicare benefits be made either to me or on my behalf to Genesis Plastic Surgery, P.C. for any services furnished me by that physician.
- 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 or the benefits payable to related services.

Date: _____ Patient or Responsible Party's Signature: _____

LIFETIME CONSENT

- I request that payment of authorized Medigap benefits be made either to me or on my behalf to Genesis Plastic Surgery, P.C. for any services furnished me by the physician.
- 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 or the benefits payable for related services.

_____ _____

Name of Beneficiary Patient's Medigap Number

_____ _____

Date Signed by Beneficiary Medigap Insurer