Referring Physician_____ Date_____

North Texas Breast and Plastic Surgery Center
Bruce Hermann M.D.

PATIENT REGISTRATION

PATIENT INFORMATION:

Last Name:_____ First Name: _____ Middle Initial:_____

Martial Status: Married_____ Single _____ Divorced _____ Separated_____ Widow_____

Sex: Female_____ Male_____ Date of Birth ____/____/____ Age:_____

Social Security Number: _____ Drivers License Number:_____

Home Address : _____

City: _____ State: _____ Zip Code: _____

Home Number :_____ Cell Number : _____

E-Mail:_____

Student Status: Full Time _____ Part Time _____ Not a Student _____

GUARANTOR (Primary Insured):

Last Name: _____First Name: _____Middle Initial:_____

Home Address : _____

City: _____ State: _____ Zip Code: _____

Home Number : _____ Cell Number : _____

E-Mail:_____

Date of Birth ____/____/____ Age:_____ Relation to Patient:_____

Social Security Number: _____ Drivers License Number:_____

Employer:_____ Employment Status: Full Time_____ Part Time_____

Not Employed/Retired_____ Occupation:_____

Name _____ Date _____

Emergency Contact:

Name: _____ Relation to Patient: _____

Address: _____

Home Phone :_____ Work/Cell :_____

E-mail: _____

Contact Consent

I, _____, the undersigned patient, authorize North Texas Breast and Plastic Surgery Center to call me at the following numbers:

A). Via Phone :_____

At Home: Yes _____ No _____ Number: _____

At Work : Yes _____ No _____ Number : _____

Cell Phone: Yes_____ No_____ Number : _____

B). Can Leave Message At:

At Home: Yes _____ No _____

At Work : Yes_____ No _____

Cell Phone: Yes_____ No_____

C). Other Person We May Leave A Message With :

Name: _____ Relationship: _____

Name : _____ Relationship: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize North Texas Breast and Plastic Surgery Center and/or Bruce Hermann M.D. to furnish information to insurance carrier's concerning my illness, accidents and treatments, and also assign to them all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I also understand that any additional co-pay, coinsurance, and/ or deductibles are due at the time of service.

Signature _____ Date _____

Section I: Financial Agreement & Assignment of Benefits

In consideration for the services to be rendered to me, I hereby assume full responsibility to pay for those services in accordance with the rates now in effect at North Texas Breast and Plastic Surgery Center, to the extent that I am legally responsible for such payment. Payments that I am responsible for may include, but are not limited to, services rendered, balance after insurance, non-covered procedures, deductibles and returned checks.

I hereby assign North Texas Breast and Plastic Surgery Center any and all benefits for services rendered under insurance policies, reimbursement, or pre-paid healthcare (health savings plan). I acknowledge any balance not covered or paid for by such policies is my legal responsibility. I understand that I must pay $75 administrative fee and a $25 processing fee plus the amount of the original check for any returned checks.

I understand that if my account is turned over to a collection agency, a 30% service charge will be added to the balance. I understand that I am required to notify North Texas Breast and Plastic Surgery Center of any address, phone number or insurance changes.

THIS IS A LEGAL FINANICAL AGREEMENT OF BENEFITS FORM. BE SURE ANY QUESTIONS YOU MAY HAVE ARE ANSWERED BEFORE YOU SIGN AT THE BOTTOM OF THE PAGE.

Section II: Receipt Acknowledgement for the Notice of Privacy Practices

I, _____have been made aware of the Notice of Privacy Practices for North Texas Breast and Plastic Surgery Center. I understand that this notice states how North Texas Breast and Plastic Surgery Center may use and disclose my "Protected Health Information" (PHI). I UNDERSTAND THAT A COPY OF THIS NOTICE IS AVAILABLE UPON REQUEST.

Section III: Medical Records Release and Forms

I understand that if I request a copy of my medical records to be sent to another doctor, I must allow 3-5 business days for processing from the time I submit a signed authorization. I understand that if I request my medical records to be released to me, I must pre-pay $35 and allow 3-5 business days from the time the signed authorization is submitted.

I understand if I submit a disability form, FMLA (Family Medical Leave Act form), or any other form that requires a doctor's signature and/or specific information to be completed, I will be charged $35 and must allow 24-48 hours for processing.

I,_____hereby authorize North Texas Breast and Plastic Surgery Center to release any information, in the course of my treatment, necessary to process insurance claims and/or to any other requesting physician(s) in reference to referrals or coordination of care.

Patient Signature

By signing below I am verifying that I have read each of the three sections on this page. I understand each section and consent to and agree with the information stated in each section.

_____ _____ _____

Patient/Legal Representative Signature Legal Representative's Relationship to Patient Date

Name_____ Date_____

NEW PATIENT INFORMATION

Age: _____

REASON FOR TODAY'S VISIT:_____

DATE OF INJURY (IF APPLICABLE) : _____ HEIGHT: _____ WEIGHT:_____

PRIOR TREATMENT OR STUDIES FOR THIS PROBLEM:_____

_____

_____

_____

_

REFERRED BY:_____ PRIMARY DOCTOR:_____

PAST MEDICAL HISTORY

Melanoma	__Yes __No	Cancer	__Yes __No	Kidney Disease	__Yes __No
Heart Disease	__Yes __No	Asthma	__Yes __No	Thyroid Disease	__Yes __No
Stroke	__Yes __No	AIDS or HIV	__Yes __No	Bleeding Tendency	__Yes __No
Anemia	__Yes __No	Hepatitis	__Yes __No	High Blood Pressure	__Yes __No
Tuberculosis	__Yes __No	Gout	__Yes __No	Mitral Valve Prolapse	__Yes __No
Diabetes	__Yes __No	High Cholesterol	__Yes __No	Bad Scarring/Keloids	__Yes __No
Lung Problems	__Yes __No	Stomach Ulcer	__Yes __No		

Do you have Sleep Apnea? __Yes ___No

Have you had Blood Clots (DVT, pulmonary embolism)? ___Yes ___No

Other medical conditions/problems: _____

_____

Prior Operations

Tonsillectomy	___Yes ___NO	Gastrointestinal	___ Yes ___No	Hand or arm	___ Yes ___No
Appendectomy	___ Yes ___No	Hysterectomy	___ Yes ___No	Heart	___ Yes ___No
Kidney/Bladder	___ Yes ___No	Hernia	___ Yes ___No		

Other operations: _____

_____

_____

FAMILY HISTORY

Breast Cancer ___Yes ___No High Blood Pressure __Yes ___ No Depression ___ Yes ___ No

Heart Disease __Yes __ No Diabetes __ Yes __No Bleeding Problems ___ Yes ___ No

Arthritis __Yes __ No Kidney Disease __ Yes __ No

Do you smoke? __ Y es No__ How much? _____ How many years? _____

If you quit smoking, when did you quit? _____

Do you drink alcohol? __Yes __No If yes, __rarely __socially ___daily __heavily

Do you use illicit drugs? __Yes __No

Do you have any of the following problems?

Weight Change __Yes __No Swollen feet __ Yes __No Seizures __Yes __No

Dry Eyes __ Yes __ No Skin rashes __Yes __No Joint/Muscle Pain __Yes __No

Chronic Cough __Yes __No Chronic Diarrhea __Yes __No Swollen Lymph Nodes _Yes _No

Chest Pain __Yes __No Jaundice __ Yes __ No Easy Bleeding _Yes _No

Rapid Heart Beat __ Yes __No Depression __Yes __No Easy Bruising _ Yes _No

Shortness of Breath __Yes __No

DO YOU HAVE ANY MEDICATIONS ALLERGIES? __ Yes _No

If yes, please list _____ _____ _____

_____ _____ _____ _____

DO YOU TAKE ANY OF THE FOLLOWING BLOOD THINNERS?

Aspirin _Yes _No Plavix _Yes _No Coumadin _Yes _No Warfarin _Yes _No NSAIDS _Yes _No

LIST ALL CURRENT MEDICATIONS (INCLUDING OVER-THE-COUNTER/HERBAL)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____