Patient Registration Form

How did you hear about us?

- ☐ Family/Friend
- ☐ Phone Book
- ☐ Internet
- ☐ Bella Via
- ☐ Physician
- ☐ Other ____________

First, Middle, Last Name Preferred Name Maiden Name

Address City, State, Zip Code Gender: ☐ Male ☐ Female

Date of Birth

Social Security Number Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Home Phone:

Cell Phone: Work Phone:

Email Address ☐ OK to email ☐ DO NOT email Employer

Race: ________________________________ Ethnicity: ______________________________ Language: ____________________________

Preferred Pharmacy (name) Pharmacy Location/Address

Family Physician (PCP) City/State/Phone Number **Referring Physician** City/State/Phone Number

Emergency Contact Information:

Name Phone Number Relationship to Patient

If patient is a minor, please list person responsible for payment:

Name/Relationship Address Phone Number

Primary Insurance Information

Insurance Company ID/Policy# Group# Co-Pay Amount

Subscriber Name Relationship to Patient Subscriber D.O.B. Subscriber SS# Employer

Secondary Insurance Information

Insurance Company ID/Policy# Group# Co-Pay Amount

Subscriber Name Relationship to Patient Subscriber D.O.B. Subscriber SS# Employer

I hereby authorize my insurance benefits to be paid directly to Reconstructive & Aesthetic Surgeons, Inc. and authorize the release of my medical information to process my insurance claims.

I understand I am financially responsible for all services rendered. I agree to pay reasonable attorney fees and all costs of collection, in the event of default.

Signed: ______________________________ **Date:** ______________

PLEASE COMPLETE REVERSE SIDE

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information.
The individual is also provided the right to request confidential communications or that communication of protected health information be made by alternative means, such as sending correspondence to the individuals office instead of the individuals home.

In order to facilitate prompt notification of appointments, surgery dates and biopsy or lab results we need your permission to leave a detailed message on your home, cell or other phone number provided.

I consent to be contacted in the following manner (check all that apply):

☐ Home ☐ Cell ☐ Work ☐ On the answering machine ☐ With anyone who answers the phone

☐ Please DO NOT CALL ____

☐ OK to MAIL to Home ☐ DO NOT MAIL TO HOME ☐ OK to Mail to Other: ______________________

☐ I permit the Practice to discuss my PHI with, and to disclose my PHI to, the following individuals:

Name	***Relationship***	***Home Phone***	***Cell Phone***

All Patients have the right to participate in their own health care decisions and to make "Advance Directives" or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the Patients expressed wishes when the Patient is unable to make decisions or unable to communicate decisions.

Please initial below as applicable:

_____ Yes, I have an "Advance Directive", Living Will or Health Care Power of Attorney
_____ No, I do not have an "Advance Directive", Living Will or Health Care Power of Attorney
_____ I would like to have information on "Advance Directives".

Signed: ________________________________ **Date:** ______________

The Privacy Rule generally requires covered entities to take reasonable steps to limit the use or disclosure of, and requests for protected health information (PHI) to the minimum necessary to accomplish the intended purposes.
These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of PHI disclosures. Information provided if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

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Medical History and Intake Form

Patient Name ____________________ **Date of Birth** / **Age** **Today's Date**

Surgeries: Please list any surgeries you have had in the past
(ex. Lasik eye, tonsils, gallbladder, hysterectomy, wisdom teeth, etc.).
Please list any cosmetic surgeries as well (please use an extra sheet if needed):

Surgery Type	Year	Surgery Type	Year

Do you have any history of anesthesia problems with surgery? ☐ **No** ☐ **Yes** **(if yes, please explain):**

Medical History: For what medical or mental conditions have you previously been or are currently being treated?
(please check all that apply, use an extra sheet if more "details" are needed):

	Yes	Details		Yes	Details
- Pt denies any past medical history			High Cholesterol		
Acid Reflux/GERD			HIV/AIDS		
ADD/ADHD			Kidney Failure		
Anxiety			Lasik Surgery		
Arthritis			Leukemia		
Artificial Joints			Neck Pain		
Back Pain			Neurologic - Seizures		
Bleeding/Blood Disorders			Neurologic - Stroke/TIA		
Breast Cancer			Prostate Disease/Cancer		
Cancer			Prosthetic Device (Implants)		
Chemotherapy			Radiation		
Cold Sores/Herpes			Respiratory - Asthma		
Diabetes - Diet control			Respiratory - COPD		
Diabetes - Insulin Dependent			Respiratory - other		
Diabetes - NonInsulin Dependent			Skin Cancer - Basal Cell		
Fibromyalgia/Chronic Fatigue			Skin Cancer - Melanoma		
Headaches/Migraines			Skin Cancer - Squamous Cell		
Hearing Loss			Skin Disease/Disorder		
Heart Disease - Arrhythmia/A-Fib			STD		
Heart Disease - history MI			Substance Abuse		
Heart Disease - other			Thyroid Disorder		
Heart Disease - Pacemaker/Defib			Tuberculosis		
Heart Disease - stents			Ulcers		
Heart Murmur/MVP			OTHER -		
Hepatitis			OTHER -		
High Blood Pressure			OTHER -		

Patient name ____________________ **Date**

PLEASE COMPLETE REVERSE SIDE

Female Questions	**#**	**Yes**	**No**
Number of pregnancies?			
Number of live births?			
Number of children breast-fed?			
Are you currently pregnant or lactating?			
Are you of childbearing potential?			

Allergies: (Including: tape, latex, medications, etc. - please use an extra sheet if needed.)

☐ No Known Allergies ☐ No Known Drug Allergies

Allergy	**Reaction (anaphylaxis, hives, rash, difficulty breathing, nausea, vomiting, etc.)**

Medications: List all medications you are taking.

(Please include vitamins, supplements, herbals, steroids, prescribed medications and any over-the-counter medications such as: aspirin, ibuprofen or other NSAIDS; use an extra sheet if needed.)

Medication	**Dose/Strength**	**For what reason/condition are you taking?**

Family History: Please list any medical conditions that have existed in your immediate family (blood relations) - please indicate if maternal or paternal:

	Yes	**Family Member**		**Yes**	**Family Member**
- No relevant family history			Kidney Disease		
-Unknown- Adopted			Leukemia		
Anesthesia Problems			Liver Disease		
Autoimmune Disorders			Lung Cancer		
Blood/Bleeding Disorder			Lung Disease		
Brain Tumor			Malignant Hyperthermia		
Breast Cancer			Malignant Melanoma		
Diabetes			Ovarian Cancer		
Drug Allergies			Prostate Cancer		
Endocrine Disease			Skin Cancer		
Heart Disease			Stroke/TIA		

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High Blood Pressure			Substance Abuse		
High Cholesterol					

____

Patient Name
Date

Social History:

Alcohol	☐	Denies alcohol use
	☐	Admits alcohol use socially
	☐	Admits alcohol use daily
	☐	Recovering alcoholic
Substance Abuse	☐	Use of a drug without medical justification-name of drug?
Illegal Drugs	☐	Denies using illegal drugs
	☐	Admits to using illegal drugs
Marijuana	☐	☐ YES ☐ No

Smoking Status:

☐	Current every day smoker
☐	Current some day smoker
☐	Former smoker –when did you stop?
☐	Never smoker
☐	Smoker, current status unknown
☐	Unknown if ever smoked
☐	Heavy tobacco smoker
☐	Light tobacco smoker

Stopped smoking date: ______________________

Height _____________ **Current Weight** _____________

***If you are being seen for a lesion, mole or skin cancer, please fill out the following:**
Lesion / Skin Cancer: Size: _________ Present How Long? _____________

Location / Site: ____

When did symptoms start? ____

How has it changed? _

Biopsy done? ________________________ What doctor? ______________________________

Sun exposure? ___________ History of skin cancer? ______________________________

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