RECONSTRUCTIVE & AESTHETIC SURGEONS, INC.

Patient Registration Form

Office Use Only
☐ INS/ID cards on file
☐ Pt Registration complete
_____

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: | Email Address

☐ OK to email
☐ OK to text for appointment reminders

Employer | Work Phone:

Preferred Pharmacy (name) | Pharmacy Location/Address

Family Physician (PCP) City/State | **Referring Physician** City/State

Emergency Contact Information:

Name | Phone Number | Relationship to Patient

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

Name/Relationship to Patient | Address | Phone Number

Primary Insurance Information

Insurance Company | ID/Policy#

Subscriber Name/Relationship to Patient | Subscriber D.O.B | Subscriber SS#

Secondary Insurance Information

Insurance Company | ID/Policy#

Subscriber Name/Relationship to Patient | Subscriber D.O.B | Subscriber SS#

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:** _____

Signed: _____ **Date:** _____

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 individual's office instead of the individual's 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

☐ 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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HISTORY & PHYSICAL

Name: _____ Age: _____

MEDICATIONS, SUPPLEMENTS, VITAMINS & OVER THE COUNTER MEDICATIONS

MEDICATION	DOSE/ STRENGTH	FOR WHAT REASON/ CONDITION ARE YOU TAKING?

LIST OF ALLERGIES; ◯ NO KNOWN DRUG ALLERGIES ◯LATEX ALLERGY

ALLERGY		REACTION

PREVIOUS SURGICAL PROCEDURES; (LIST ALL SURGERIES INCLUDING TONSILS, LASIK EYE, WISDOM TEETH ETC.)

DATE or @ AGE	SURGERY TYPE

MEDICAL CONDITIONS:

BREAST: ◯ BREAST CANCER ◯ ASYMMETRY ◯ BREAST IMPLANTS ◯ COSMETIC CONCERNS ◯ NONE

OTHER_____

CARDIOVASCULAR: ◯ ABNORMAL EKG ◯ ATRIAL FIBRILLATION ◯ ARRHYTHMIA ◯ CONGESTIVE HEART FAILURE ◯ HEART ATTACK ◯ HIGH BLOOD PRESSURE ◯ DEFIBRILLATOR ◯ PACEMAKER ◯ STENTS ◯ NONE

OTHER_____

HEMATOLOGIC: ◯ ANEMIA ◯ BLEEDING DISORDER ◯ BLOOD CLOTS ◯ DEEP VEIN THROMBOSIS ◯ PULMONARY EMBOLISM ◯ NONE

OTHER_____

(PLEASE COMPLETE REVERSE SIDE)

RESPIRATORY: ◯ ASTHMA ◯ CHRONIC COUGH ◯ COPD ◯ EMPHYSEMA ◯ OXYGEN USE ◯ SLEEP APNEA/ CPAP/ BiPAP ◯ NONE

OTHER_____

PYSCHIATRIC: ◯ ANXIETY ◯ BIPOLAR ◯ DEPRESSION ◯ SCHIZOPHRENIA ◯ NONE

OTHER _____

SKIN: ◯ BASAL CELL ◯ SQUAMOUS CELL ◯ MELANOMA ◯ PRECANCER ◯ SKIN DISEASE ◯ NONE

OTHER_____

OTHER: ◯ CHEMOTHERAPY ◯ DIABETES ◯ HIV/AIDS ◯ HX OF ALCOHOL/ DRUG ADDICTION ◯ LYMPHEDEMA ◯ MALIGNANT HYPERTHERMIA ◯ MRSA ◯ MUSCULOSKELETAL DISORDER ◯ MULTIPLE SCLEROSIS ◯ PROBLEMS WITH ANESTHESIA ◯ RADIATION ◯SEIZURES ◯ NONE

OTHER_____

FAMILY MEDICAL HISTORY: ◯ ANESTHESIA PROBLEMS ◯ BLOOD/BLEEDING DISORDER ◯ MALIGNANT HYPERTHERMIA ◯ MELANOMA ◯NONE

SOCIAL HISTORY:

TOBACCO/ NICOTINE/ VAPING: ◯ NEVER ◯ CURRENTLY ◯ PREVIOUSLY HOW MUCH? _____ QUIT WHEN? _____

CANNABIS/ MARIJUANA: ◯ NEVER ◯ CURRENTLY ◯ PREVIOUSLY HOW MUCH? _____ QUIT WHEN? _____

ALCOHOL: NUMBER OF DRINKS PER DAY/ WEEK; _____

DO YOU OR HAVE YOU USED OPIOIDS? ◯ YES ◯ NO IF SO, WHEN? _____ FOR WHAT REASON? _____

DO YOU OR HAVE YOU USED ILLICIT DRUGS? ◯ YES ◯ NO WHICH DRUGS? _____

ARE YOU CURRENTLY PREGNANT OR LACTATING? ◯YES ◯ NO NUMBER OF BIRTHS? _____

HEIGHT: _____ **WEIGHT**: _____