Member
AMERICAN SOCIETY OF
PLASTIC SURGEONS

PLASTIC SURGERY CLINIC OF N.W. ARKANSAS

AESTHETIC AND RECONSTRUCTIVE SURGERY

H. DANIEL ATWOOD, M.D. F.A.C.S.

MEMBER OF THE AMERICAN SOCIETY
FOR AESTHETIC PLASTIC SURGERY

1794 JOYCE, SUITE 1
FAYETTEVILLE, ARKANSAS 72703

(479) 443-7771
OR TOLL FREE
1 (800) 632-4601

NEW PATIENT INFORMATION

PATIENT DATA

NAME			SEX M F	DATE OF BIRTH	AGE
STREET ADDRESS	CITY	STATE	ZIP	CELL PHONE #	HOME PHONE
OCCUPATION	EMPLOYER	EMPLOYER ADDRESS			
WORK PHONE	SOCIAL SECURITY NUMBER	MARITAL STATUS M ☐ D ☐ S ☐ W ☐		NAME OF SPOUSE	
NEXT OF KIN:		PHONE:			
MAY WE LEAVE YOU A MESSAGE? _____ YES _____ NO If Yes, where? _____					

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

NAME OF PERSON RESPONSIBLE FOR BILL:			RELATIONSHIP TO PATIENT	
HOME ADDRESS	CITY	STATE	ZIP	HOME PHONE
OCCUPATION	EMPLOYER	EMPLOYER ADDRESS		
WORK PHONE	SOCIAL SECURITY NUMBER	COMMENTS		

GENERAL INFORMATION:

PURPOSE OF TODAY'S VISIT:	
IS THIS INJURY REGARDING AN ACCIDENT? YES ☐ NO ☐	JOB ☐ DATE _____ MVA ☐ DATE _____ OTHER _____
WHO REFFERED YOU TO OUR OFFICE?	WHO IS YOUR PRIMARY PHYSICIAN?
HOW DID YOU FIND OUT ABOUT OUR OFFICE?	

INSURANCE:

PRIMARY COVERAGE NAME OF INS. CO.		SECONDARY COVERAGE NAME OF INS. CO.	
ADDRESS		ADDRESS	
NAME OF POLICY HOLDER:		NAME OF POLICYHOLDER:	
POLICY #:	GRP. #:	POLICY #:	GRP. #.
POLICYHOLDER'S DATE OF BIRTH:		POLICYHOLDER'S DATE OF BIRTH:	
MEDICARE:			
MEDICAID:			
DOES YOUR INSURANCE CO. REQUIRE 2ND OPINION PROGRAM _____ PRE-CERTIFICATION _____			
PRE-EXISTING (DATE POLICY IN EFFECT) _____			

ASSIGNMENTS: PLEASE READ!

I authorize the release of my medical records from Dr. Atwood to any physicians, hospitals, other facilities, or individuals involved in my medical care: I further authorize the aforementioned individuals/institutions to release to Dr Atwood any information pertaining to my medical care.
I hereby authorize payment directly to Dr. H. Daniel Atwood for the surgical and/or medical benefits that he is entitled to under my medical-surgical insurance plans. I understand that I am responsible for any unpaid balance.
I hereby authorize Dr. Atwood to perform such examinations, as are indicated and necessary for adequate evaluation of the condition for which I am presenting myself to Plastic Surgery Clinic of N.W. Arkansas.
I understand that a fee(s) is charged for all first visits, examinations, or medical reports. Fees for special medical reports to attorneys are payable in advance. I understand that ALL COSMET IC SURGERY FEES ARE PAYABLE TWO WEEKS IN ADVANCE.

I understand that photographs will be taken for confidential, clinical records and will remain property of the doctor.

PATIENT'S SIGNATURE	DATE	IF PATIENT IS A MINOR, SIGNATURE OF PARENT OR GUARDIAN.

SPENCER PRINTING, INC 751-2184

Medical History

NAME: _____ AGE: _____

DATE OF BIRTH: _____ FAMILY DOCTOR _____

CHIEF COMPLAINT _____

REVIEW OF SYSTEMS: Please answer yes and give date if you have had or now have any of the following:

	YES	DATE
GENERAL:		
weight change	_____	_____
bleeding disorder	_____	_____
anemia	_____	_____
diabetes	_____	_____
HEART AND LUNGS:		
asthma-bronchitis	_____	_____
pneumonia	_____	_____
emphysema	_____	_____
cough up blood	_____	_____
tuberculosis	_____	_____
shortness of breath	_____	_____
chest pain/angina	_____	_____
ankle swelling	_____	_____
high blood pressure	_____	_____
rheumatic fever	_____	_____
heart murmur	_____	_____
FEMALE:		
menopause (age)	_____	_____
nipple discharge	_____	_____
breast lumps	_____	_____
fibrocystic	_____	_____
CANCER:	_____	_____
ARTHRITIS:	_____	_____
HEIGHT:	_____	
WEIGHT:	_____	

	YES	DATE
HEAD, NECK, AND NERVOUS SYSTEM:	_____	_____
meningitis	_____	_____
seizures	_____	_____
head injury	_____	_____
paralysis	_____	_____
ear infection/disease	_____	_____
deafness	_____	_____
eye infection/disease	_____	_____
vision difficulty	_____	_____
nose bleed	_____	_____
thyroid disorder	_____	_____
ABDOMEN:		
ulcers/pain	_____	_____
vomit blood	_____	_____
black/bloody stool	_____	_____
hepatitis/jaundice	_____	_____
gallbladder disorder	_____	_____
KIDNEY AND GENITAL:		
blood in urine	_____	_____
kidney disease	_____	_____
venereal disease	_____	_____

PAST MEDICAL HISTORY: Please list and date

MAJOR ILLNESSES AND DISEASES: _____

_____

_____

SURGERIES: _____

_____

HOSPITALIZATIONS:

Hospital	Date	Condition	Doctor

ALLERGIC HISTORY: Are you allergic to:
penicillin_____ sulfa_____ codeine_____ demerol_____ tetanus_____

other _____

MEDICATIONS: List any medications you now take or have taken in the past years and for what reasons (including birth control pills)

_____

_____

HABITS: Do you smoke? _____ Packs per day? _____ Do you drink? _____

FAMILY HISTORY: List any diseases known in your family:

_____

_____

_____

_____

I verify that the above information is true and accurate to the best of my knowledge.

Sign _____ Date_____

Plastic Surgery Clinic of Northwest Arkansas

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Plastic Surgery Clinic
(print name)

of Northwest Arkansas' Notice of Privacy Practices.

_____ _____
Signature of Patient Date

You have my permission to discuss my Patient Health Information with the following

People: _____

_____

_____

_____

_____

_____

_____

_____ _____
Signature of Patient Date