PATIENT REGISTRATION FORM

Acct # _____

Patient Information

Legal First Name _____ M.I. _____ Last Name _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Email _____

Employer _____ Work # _____

Birth Date _____/_____/_____ Social Security # _____ or Drivers License # _____

Gender: M / F **Marital Status:** Married Single Divorced Other **Preferred Language:** English Other _____

Ethnicity: Hispanic/Latino Non Hispanic/Latino **Race:** Caucasian African American Asian Other _____

Referred by _____ Primary Physician _____

Responsible Party

Legal First Name _____ M.I. _____ Last Name _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Email _____

Birth Date _____/_____/_____ **Gender:** M / F

Social Security # _____ or Drivers License # _____

Employer _____ Work # _____

Insurance Information

Primary Insurance Company _____

Address _____
Street City State Zip

ID Number _____ Group Number _____

Insured Name _____ Insured DOB _____

Insured Employer _____ Relationship to Patient _____

Secondary Insurance Company _____

Address _____
Street City State Zip

ID Number _____ Group Number _____

Insured Name _____ Insured DOB _____

Insured Employer _____ Relationship to Patient _____

Financial Policy: I authorize the release of any information necessary to process claims. I request payment of benefits to Precision Plastic and Hand Surgery I understand I am financially responsible for charges not covered by insurance. I hereby authorize to Precision Plastic and Hand Surgery and its employees and/or agents to release all information, reports and records if necessary for the purposes of treatment, payment and healthcare operations, including a discussion of my medical condition to the insurance provider, rehabilitation provider, employer, hospitals and doctors.

If your plan has a co-payment, deductible and/or co-insurance you will be expected to pay your portion prior to receiving any service. You may be required to pay a minimum of 50% at the time of service until we verify your deductible has been met.

Any cancellation or change of a scheduled appointment/procedure requires a minimum of 24 hours notice. Any appointment canceled with less than 24 hours notice will result in a cancellation fee of $35.00. There will be a $100 cancellation/ no show fee for missed surgery appointments.

Payment is due at the time of service unless prior financial arrangements have been made with our business office. Any account balance is expected to be paid in full prior to new services being rendered. If your account is turned over to an outside collection agency, you may be held liable for collection agency fees and/or attorney fees. In the event that payment arrangements have not been made 90 days after the date of service, a late-fee of 50% of your outstanding balance will be applied to your account and your account will be turned over to our collection agency.

Patient/Responsible Party Signature _____ **Date** _____

Patient Health Summary
-Continued-

List ALL medication you are currently taking (including prescriptions, vitamins, and herbals): Please use other side of needed

1)_____ 6)_____
2)_____ 7)_____
3)_____ 8)_____
4)_____ 9)_____
5)_____ 10)_____

Are you taking ANY blood thinners or Aspirin? YES NO

Medication Allergies: _____

Other Allergies: _____

Family Medical History:

_____

_____

Past Surgeries:

_____

Do you Smoke? Never Former Current
If Yes, how much per day: _____
Do you Smoke Marijuana? Never Former Current
How often do you have an alcoholic beverage?
Never 2-3 month 4-6 month 7-10 month
How many drinks do you typically have?
1-2 3-4 5-6 7+

Consent to treat: I, myself (or the patient names below), Hereby consent for examination and treatment as necessary and appropriate for my condition or illness by Christopher P. Fender, M.D. I have read and understand the terms of treatment and confirm that I am the patient or I am authorized to sign on patient's behalf.

_____

Signature of patient/legal guardian Date

Precision Plastic and Hand Surgery
Patient Health Summary

Today's Date_____

Patient Name: _____ **Age:**_____ **Weight:**_____ **Height:**_____

Dominant Hand: (Right/Left)

Reason for today's visit: _____

Have you been previously diagnosed with any of the following? Please indicate any medical problems not listed below in the "other" box.

- o Arthritis
- o Atrial Fibrillation (irregular heartbeat)
- o Breast cancer
- o Cancer other _____
- o COPD
- o Coronary Heart Disease
- o Depression
- o Diabetes
- o Hearing Loss
- o Heart valve replacement
- o Hepatitis
- o HIV/AIDS
- o High blood pressure
- o High Cholesterol
- o Hypothyroidism
- o Hyperthyroidism
- o Depressed immune system
- o Inflammatory Bowel Disease
- o Joint Replacement
- o Pins or Rods
- o Radiation Treatment
- o Seizures
- o Stroke
- o Transplant
- o Other: _____

- o Nausea/Vomiting
- o Diarrhea
- o Constipation
- o Heart Burn/Reflux
- o Blood Clots
- o Muscular Weakness
- o Joint Pain
- o Muscle Pain
- o Muscle Cramps
- o Tremor
- o Loss of Balance
- o Numbness/Tingling
- o Basal cell carcinoma
- o Melanoma
- o Squamous cell carcinoma
- o Dysplastic or Atypical moles

I attest that the provided information is accurate and complete:

Signature: _____ **Date:** _____

Acct # _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Precision Plastic and Hand Surgery to use or disclose my Personal Health Information (PHI) as
described below. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider, the released PHI may no longer be protected by federal privacy regulation. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice. It is available upon request.

Patient authorizes communication with family/friends regarding your **care and test results.**

Name _____ Phone # _____ Relation_____

Name _____ Phone# _____ Relation_____

Patient authorizes communication with family/friends regarding your **account and billing.**

Name _____ Phone # _____ Relation_____

Patient authorizes communication with a primary care physician or other physician (first and last name):

1. _____ M.D.
2 _____ M.D.

Best way to contact you regarding messages, responses, appointment reminders etc. (number 1- 5, 1 being the best)

Home phone__ Work phone__ Cell phone__ E-mail Text

May we leave a message on home voicemail?	Yes	No	N/A
May we leave a message with whomever answers the home phone?	Yes	No	N/A
May we call your work and leave a message with the person who answers the phone?	Yes	No	N/A
May we leave a message on work voicemail?	Yes	No	N/A
May we contact you via Email? Email Address:_____			
May we contact you via text message? _____	Yes	No	N/A
May we send out your PHI to a third party system?	Yes	No	N/A

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI in reliance on your consent.

May we fax and/or email to other providers if necessary to medical care	Yes	No	N/A

Signature of patient (or patient's representative)_____ Date _____

Printed legal name of patient (or patient's representative) _____