Image *Sculptors*

Plastic Surgery *Medical Day Spa*

Dr. Laura L. Bennett

PERSONAL DATA:

Full name: _ ______________________ Name you like to be called: _________________

Address: _____________ _______ City: ________________

State: ____ Zip: ____

Date of birth: ____________________________ Age: ___ Sex: ____

SS#: _____________

Home Phone: ______________ Work Phone: ______________

Cell phone: _____________

E-mail address: ____

Which phone should we contact you on? ____

May we leave messages on this phone? Y ___ N ___ May we email you? Y ___ N ____

RESPONSIBLE PARTY (for minors under 18):

Name: ______________________________ DOB: ________________ Relation to patient: _________________________

Address: ____ City: ______________ State: ______ Zip: ______

Daytime phone: _________________________ Evening phone: __________________ Cell phone: ______________

AUTHORIZED PERSONS: (persons we can communicate with regarding appt/treatment)

Name: ____ Relation to patient: ____________________________

Work Phone:____ Home Phone:___________________________________

Name: ____ Relation to patient: ____________________________

Work Phone:____ Home Phone:___________________________________

EMPLOYER INFORMATION: (PATIENT OR GUARDIAN/PARENT)

Employer: ____ Occupation: ____________________________

Employer's address: ______________________________________ Phone number: _________________________

REFERRAL INFORMATION:

Physician referral: _______________________ Patient referral: ____________________ Other: __________________

Primary Care Physician_______________________

1665 Antilley Rd. Ste. 285 Abilene, Texas 79606 Office 325.793.5128

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What is the reason you are coming in today?:____

Due to an injury? Y N On the job injury? Y N Auto accident? Y N Date of injury/accident: _________________

PAST MEDICAL HISTORY: (Have you ever had any of the following medical conditions?)

High blood pressure	Y	N	Stomach ulcer or gastritis	Y	N
Heart attack or congestive heart failure	Y	N	Hepatitis or other liver disorder	Y	N
Heart murmur or heart valve disorder	Y	N	Kidney disease or failure	Y	N
Asthma, bronchitis or COPD	Y	N	History of blood clots in the veins of your legs	Y	N
Sleep apnea, or use CPAP	Y	N	Stroke or paralysis	Y	N
Anemia or any other blood disorder	Y	N	Diabetes or thyroid disorder	Y	N
Transfusion of blood or blood products	Y	N	Autoimmune disease	Y	N
Glaucoma or other eye disorder	Y	N	Arthritis or degenerative joint disease	Y	N
Seizure disorder	Y	N	Cancer (What type? __________________)	Y	N
Depression, anxiety or any psychiatric disorder?	Y	N			

Any other medical problems (Be specific): ____

PAST SURGICAL HISTORY: (List all previous operations by date and any associated problems with the surgery or anesthetic)

SURGERY	*DATE*	*PROBLEMS WITH SURGERY OR ANESTHETIC*
________________	________	________________
________________	________	________________

ALLERGIES: (Reaction to any medication, drug or anesthetic)

MEDICATION	*REACTION*
____________	____________
____________	____________
____________	____________

MEDICATIONS: (**All** prescription and over-the-counter medications)

MEDICATION	*DOSE / FREQUENCY*
____________	____________
____________	____________
____________	____________

SOCIAL HISTORY:

Marital status: *S M D W* Number of children: ____ Children at home: ____ Hobbies: ____________________

Do you use tobacco/Nicotine products (gum, patches, etc.) ***Never In the past Occasionally Regularly***

Amount/day: ___________ Number of years: ___________ If yes, explain: ________________________

Do you drink alcohol? ***Never In the past Occasionally Regularly*** Amount/day: ___________ Number of years: ___________

FAMILY HISTORY: (Any history of the following conditions in a blood relative? Which family members?)

High blood pressure	Y	N	____________	Heart disease	Y	N	____________
Diabetes	Y	N	____________	Stroke	Y	N	____________
Cancer (type)	Y	N	____________	Bleeding disorder	Y	N	____________

REVIEW OF SYSTEMS: (Have you recently experienced or do you currently experience any of the following symptoms?)

Recent weight loss or easy fatigability	Y	N	Pain or burning when you urinate	Y	N
Fever, chills or night sweats	Y	N	Pain in your extremities or major joints	Y	N
Change in vision or temporary loss of vision	Y	N	Slow wound healing or excessive scaring	Y	N
Excessive tearing or excessively dry eyes	Y	N	Change in size or color of a mole or other growth	Y	N
Irregular heart rate or palpitations	Y	N	New lumps or discomfort in your breast	Y	N
Tightness, pressure or pain in your chest	Y	N	Dizziness, light-headedness or faintness	Y	N
Swelling of your feet or ankles	Y	N	Weakness in any extremity	Y	N
A recent cold, flu or pneumonia	Y	N	Any unusual stress in your life at this time	Y	N
Wheezing or shortness of breath	Y	N	Any chance that you may be pregnant	Y	N
Heartburn or reflux	Y	N	Excessive or prolonged bleeding when cut	Y	N
Frequent loose stools or constipation	Y	N	Any known deficiency of your immune system	Y	N
Blood in your stool or urine	Y	N	Allergy or reaction to Latex	Y	N

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PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

(Please initial appropriately)

I hereby give permission to take clinical photos for the purpose of clinical planning and documentation. I may request a copy of these photographs at any time.

Occasionally clinical photos are used for the advancement of surgical knowledge for professionals, students and the public.

_______ I will _______ I will not permit the use of my photographs for ethical professional clinical use (including viewing of the photographs by other patients)

_______ I will _______ I will not permit the use of my photographs for medical publishing.

_______ I will _______ I will not permit the use of my photographs for use on the ***Image Sculptors*** website. So long as my identity is kept confidential by removing all identifying features.

_______ I will ________I will not permit the use of my photo and testimonial for use of the ***Image Sculptors*** website and affiliated sites.

__________________________ Patient

______________________ Date

___________________________ WITNESS/PHYSICIAN

______________________ Date

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by ***Image Sculptors at ADC*** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of ***Image Sculptors at ADC***. I understand that diagnosis or treatment of me by may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. ***Image Sculptors at ADC*** is not required to agree to the restrictions that I may request. However, if ***Image Sculptors at ADC*** agrees to a restriction that I request, the restriction is binding on ***Image Sculptors at ADC*** and .   I release all medical records to , and all records created at ***Image Sculptors at ADC*** are the property of Dr Bennett.

I have the right to revoke this consent, in writing, at any time, except to the extent that or ***Image Sculptors at ADC*** has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review ***Image Sculptors at ADC*** ‘s Notice of Privacy Practices prior to signing this document. The ***Image Sculptors at ADC***'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of ***Image Sculptors at ADC***. This Notice of Privacy Practices also describes my rights and the ***Image Sculptors at ADC*** 's duties with respect to my protected health information.

Image Sculptors at ADC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the ***Image Sculptors at ADC***'s website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

This is a notice informing you that federal law and the Texas patient Solicitation ACT (TPSA) requires that we notify you that Dr. Bennett may have a direct or indirect ownership interest in Abilene Regional Medical Center. As an owner, she may, directly or indirectly, receive compensation for items or services you may receive from such entity. By signing below, you are acknowledging that you have received a notice of the information provided above.

____ ________________________________

Signature of Patient or Personal Representative — Date

____ ________________________________

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Insurance Information & Authorization

(Please Print Legibly & Sign)

Patient's Name ____
First Middle Last

Primary Insurance Company ____

Policyholder's Information: Policy Number: SS#

Name ____ Birthdate ___/___/______

Employer ______________________________ Relationship to Patient ______________

Does this insurance required a referral? ❒ Yes ❒ No Copay Amount $ __________

Secondary Insurance Company ____

Policyholder's Information: Policy Number:

Name ____ Birthdate ___/___/______

Employer ______________________________ Relationship to Patient ______________

Does this insurance required a referral? ❒ Yes ❒ No Copay Amount $ __________

Is this visit due to any type of accident? ❒ No ❒ Yes: Date of Accident ______________

Type of Accident ❒ Auto: State? _______ ❒ Work Related ❒ Other: ______________

All Patients – Signature on File

I request that payment of authorized benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services. I understand that I am financially responsible for all fees and charges not paid by my insurance company and that they are due and payable within 45 days of service unless other arrangements have been made with the office. I further understand that should ***Image Sculptors at ADC*** have to refer my account for outside collections that I am responsible for all fees incurred by the agency or attorney/legal fees.

Beneficiary Signature ______________________________ DOB Date ________

Medicare Patients Only – Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature ______________________________ Date ______________