

# Green Hills Plastic Surgery

Stephen M. Davis, MD, FACS

## General Information

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

M.I.

How would you like to be addressed by our office staff? \_\_\_\_\_

Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse or Significant Other's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Home

Street

City

State

Zip Code

Emergency Contact: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

## Phone Numbers

Please circle the phone number you prefer us to use FIRST in contacting you.

Home: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Fax: ( ) \_\_\_\_\_ E-Mail: \_\_\_\_\_

## Today's Visit

Referred By: \_\_\_\_\_ May we correspond with them? Yes / No

What would you like to discuss with Dr. Davis today? \_\_\_\_\_

Have you consulted other physicians concerning this? Yes / No

## Medical History

Primary Care Physician: \_\_\_\_\_ Current Weight: \_\_\_\_\_ Height: \_\_\_\_\_

When did you have the following last?

Physical Exam: \_\_\_\_\_ EKG: \_\_\_\_\_ Chest X-Ray: \_\_\_\_\_

Blood Work: \_\_\_\_\_ Mammogram: \_\_\_\_\_ T-Cell Count: \_\_\_\_\_

Please circle all of the following medical conditions you have or had in the past

### Heart

High Blood Pressure

Heart Attack

Irregular Heart Beat

Chest Pain

Heart Disease

### Resp

TB

Asthma

Wheezing

Emphysema

Bronchitis

### Bleeding/Liver

Bleeding Tendency

Hepatitis

Diabetes

HIV

### Eyes

Glaucoma

Cataracts

Dry Eyes

Eye Surgery

### GI

Intestinal Ulcers

Intestinal Bleeding

Heartburn

Reflux

### Mental

Depression

Mental Illness

Alcohol or

Drug Addiction

### **Surgical History**

Please list all types of surgical procedures including *injuries, hospitalizations, and cosmetic procedures.*

**Name of Surgery:**

**Date:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

### **Anesthesia History**

Please circle all which apply:

Nausea: Yes / No

Vomiting: Yes / No

Headaches: Yes / No

Breathing Problems: Yes / No

High Fever: Yes / No

Muscle Weakness: Yes / No

Other anesthesia problems or complications: \_\_\_\_\_

### **Gynecological History**

Number of Pregnancies: \_\_\_\_\_ Normal Deliveries: \_\_\_\_\_ C-Sections: \_\_\_\_\_

Miscarriages: \_\_\_\_\_ Last Menstrual Period: \_\_\_\_\_

Date of Last Gynecological Exam: \_\_\_\_\_ Do you take oral contraceptives or Estrogen? Yes / No

### **Social History**

Do you exercise regularly? Yes / No If so, how? \_\_\_\_\_

Have you ever smoked? Yes / No If yes, do you still smoke? Yes No

What age did you start smoking? \_\_\_\_\_ What age did you stop smoking? \_\_\_\_\_

How many packs per day do/did you smoke? \_\_\_\_\_

Do you drink alcohol? Yes / No

How much do you drink per day/week? \_\_\_\_\_

### **Family History**

Do any diseases run in your family including blood related diseases/conditions? Yes / No

**Name of Disease/Condition**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Medicines:**

**Name of Medicine:**

**Dose:**

**Frequency Taken:**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

Do you have allergies to any medicines? Yes / No

**Name of Medicine:**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## **INSURANCE INFORMATION and AUTHORIZATION**

Name of Insured: \_\_\_\_\_

Relationship to Patient: Self \_\_\_\_\_ My Spouse \_\_\_\_\_ My Parent(s) \_\_\_\_\_

**If your insurance is under another person's plan, please complete the following information:**

Insured's Date of Birth: \_\_\_\_\_ Insured's Social Security Number: \_\_\_\_/\_\_\_\_/\_\_\_\_

### **Insurance Authorization:**

I hereby authorized my insurance benefits to be paid directly to *Green Hills Plastic Surgery*. I realize that I am responsible for any fees not covered by my insurance policies. I also authorize the release of pertinent medical information to my insurance carriers.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## **PATIENT'S RIGHTS**

Effective April 14, 2003, the Federal Government set a law in place to protect you and the release of your medical information. We at *Green Hills Plastic Surgery* promise to do our part in upholding this law. Our office is permitted by Federal law to make uses and disclosures of your health information for purposes of treatment, payment and healthcare operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examinations, test results, diagnoses, treatment and applying for future care or treatment. It also includes billing documents for those services.

***A copy of the Federal Privacy Law is available to you at your request.***

I would like a copy of the Federal Privacy Law: Yes \_\_\_\_\_ No \_\_\_\_\_

**I have read the above information regarding the Federal Privacy Law and understand my rights as a patient of *Green Hills Plastic Surgery*.**

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Patient Agreement

Limitation of Practice: Patient understands that Dr. Davis's practice is limited to Plastic and Reconstructive Surgery.

Patient Consent: Patient hereby gives my consent, if needed, for drawing blood samples for diagnosis or in case of accidental puncture or exposure to medical personnel during my course of treatment either in the offices or in the hospital. These tests may include HIV testing.

## Collection Policy

### Insurance Claims Filing

*In all cases, the patient is responsible for payment of their account. As a courtesy, we will file a claim to the patients' insurance coverage.*

Assignment and Release: Patient hereby authorizes and assigns applicable insurance benefits to be paid directly to the physician. The patient is financially responsible for non-covered services. The patient authorizes release of information necessary to process insurance claims. Patient authorizes photographs to be restricted for medical, education, or insurance purposes and information released to other practitioners in good faith effort for my medical care.

Medicare: Patient requests that payment of authorized Medicare benefits be made either to the patient or on the patient's behalf to Stephen M. Davis, M.D. and their associates for any services furnished the patient by that physician. Patient authorizes any holder of medical information about the patient to release to the Health Care Financing Administration (Medicare) or its agents any information needed to determine these benefits payable for related services. This form is not to be used by the patient for Medicare reimbursement.

### Managed Care Plans and Referrals

Managed care plans (e.g. HMO's) require specialist and sub-specialists to obtain a referral number before a patient can be seen by the physician. The patient is responsible for obtaining a referral number, not this office. Failure to have a referral number prior to service will result in reduced benefits by the managed care plan. Therefore, the patient is responsible for any balance not paid by the coverage plan.

### Co-Payments

In all cases, the patient is responsible for making co-payments at the time of the patient visit in the form of cash or check. If a co-payment is not made at the time of the patients visit, Stephen M. Davis, M.D. reserves the right to require co-payment to be made prior to all future patient visits.

## Maximum 30 Day Period for Unpaid Balances

Patient Balances are due 30 days after insurance coverage payment has been made. In the alternative, the patient must make acceptable payment arrangements by contacting the Administration. Balances may be paid via cash, check, Visa, or MasterCard.

### Unpaid Balances

If for any reason the patient cannot make scheduled payments, the patient must immediately contact the Administrator to make acceptable arrangements. Stephen M. Davis, M.D. reserves the right to refer all unpaid accounts to collection agencies. Any fees associated with collection, including attorney fees, collection agency contingency fees and court costs, will be added to the patient's account balance. After accounts are placed with collection agencies, all patient visits and procedures will be one cash only basis.

### Service Charge

Stephen M. Davis, M.D. reserves the right to assess a service charge, not to exceed \$20 per month, to a patient account for any unpaid balance over 30 days after the insurance coverage has been paid. No service charges will be assessed to patient account where the patient has made payment arrangements with the Administrator and payments are being made as agreed.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

\*If Responsible Party is different than the patient, please complete:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone Number: \_\_\_\_\_

Employer Address: \_\_\_\_\_

ALL QUESTIONS CONCERNING THESE POLICIES  
SHOULD BE DIRECTED TO THE ADMINISTRATOR  
AT (615) 327-7407