

plasticsurgeryinnovations_{P.C.}

Patient Information

Patient's Name

First

Middle Initial

Last

Address

Street & Apt #

City

State

Zip

SS#

Gender

 Male

Marital Status

 Single

Birthdate

 Female Married to:

Age

 Other:

Home phone:

Can we leave a message for you at home?

 Yes No

Work phone:

Can we leave a message for you at work?

 Yes No

Cell phone:

Can we send you a text message?

 Yes No

Email address:

Can we send email to this address?

 Yes NoPreferred method of contact: Home Work Cell

Occupation:

Employer:

In case of emergency, contact:

Relationship to patient:

Home phone:

Work/Cell phone:

Complete this section only if someone other than the patient is financially responsible.

Responsible Party:

Relationship to Patient:

Address:

Home phone:

Birth Date:

SS#

Primary Health Insurance

Name of Insurance Company:

Insured's Name

Birth date:

SS#

Insured's Employer

Policy ID#

Group#

Secondary Health Insurance

Name of Insurance Company:

Insured's Name

Birth date:

SS#

Insured's Employer

Policy ID#

Group#

All Commercial Insurance – 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.

Beneficiary Signature

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

Payment Policy

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Mlakar to bill my insurance company. I agree to pay all deductible, copay, and non-covered service amounts. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Mlakar and myself.

Signature

Date

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Notice of Privacy Policy

Patient's Name: _____

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may request a revised copy from the Privacy Officer.

Please list any persons (other than insurance carriers and healthcare professionals) who are authorized to receive protected health information about you:

No one

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

By signing this form, you acknowledge your right to revoke your consent in writing except to the extent that the practice has already made disclosures in reliance upon your prior consent.

Patient Signature
(Parent/Guardian Signature if patient is under the age of 18 years)

Date

Patient Photography Authorization and Release

- I consent to the taking of photographs or videotapes of me or parts of my body, by Dr. Joseph M. Mlakar or his designee, in connection with my medical care or with the plastic surgery procedure(s) to be performed by Dr. Joseph M. Mlakar. Preoperative and postoperative photographs of my person will be used for confidential clinical record purposes only, and shall remain the property of Dr. Joseph M. Mlakar.
- I further consent to the release by Dr. Joseph M. Mlakar or his designated representatives of such photographs, videotapes or case histories to the appropriate insurance companies for surgical pre-authorization and/or claim review.

I fully and specifically grant my permission for the use of photographs, videotapes or case information for the following additional purposes as indicated by my initials below. As a result of this use I understand that these photographs, videotapes, or case information may appear in other related, updated, or reprinted formats at any concurrent or future occasion. Neither I, nor any member of my family, will be identified by name in any publication. I understand that such consent is strictly on a volunteer basis. I understand that I may refuse to sign this additional authorization and such refusal will have no effect on the medical treatment I receive from Dr. Joseph M. Mlakar. I understand a copy of this consent may be supplied with images to any third party wherein they may be published, or presented. I understand that some photographs may, by their representation make me identifiable in appearance to others. I authorize Dr. Joseph M. Mlakar to use my photographs, videotapes, and case information in the following educational or scientific settings **that I have initialed**:

- _____ Medical journals and textbooks, scientific presentations and teaching courses in any prior, visual or electronic media, for the purpose of informing the medical profession about plastic surgery methods.
- _____ My surgeon's office patient education materials, including pre- and postoperative photographs available only to prospective patients for viewing in the office.
- _____ My surgeon's personal web site or web page.
- _____ Lectures and multimedia presentations given by my surgeon for the general public.
- _____ Television programs in which my surgeon participates.
- _____ Newspaper or magazine articles in which my surgeon participates.
- _____ Case studies presented on professional, society web sites.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) years from the date written below.

I understand that the information disclosed, or some portion thereof may be protected by state law and/or the federal Health insurance Portability and Accountability Act of 1996 ("HIPAA").

I release and discharge Dr. Joseph M. Mlakar, and all parties acting under their license and authority from all rights that I may have in the photographs, videotapes or cast histories and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these materials in any medium.

I grant this consent as a voluntary action and certify that I have read the above Authorization and Release and fully understand its terms.

Patient Name

Date

Patient Signature
(Parent/Guardian Signature if patient under the age of 18 years)

Date

Witness

Date

Medical History

Name: _____ Date: _____
 First M.I. Last

Birth date: _____ Age: _____ Weight: _____ Reason for Visit: _____

Parent(s)/Guardian(s): _____ Referring Dr.: _____ Other Drs.: _____

ALLERGIES Environmental allergies Latex allergies Tape allergies No known drug allergies Drug allergies:

List all DRUG ALLERGIES and type of reaction: _____

MEDICATIONS, VITAMINS & SUPPLEMENTS Attach list if more than five prescription medications

Rx: _____ Dose: _____ Reason: _____

Rx: _____ Dose: _____ Reason: _____

Rx: _____ Dose: _____ Reason: _____

Rx: _____ Dose: _____ Reason: _____

Rx: _____ Dose: _____ Reason: _____

Do you use any of the following? Mark all that apply: Insulin Coumadin Home Oxygen Aspirin or ibuprofen Steroids

PERSONAL PAST MEDICAL HISTORY Have you ever had any of the following?

	Yes	No		Yes	No		Yes	No
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Attention deficit	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Sickle-cell disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	Birth defect	<input type="checkbox"/>	<input type="checkbox"/>
Coronary stents	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/ Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Type of cancer: _____		

No major illnesses or hospitalizations

Other: _____

Have you been hospitalized in the past 6 months? No Yes: _____

Are your immunizations current? Yes No Unsure Special Needs: Religious/Ethnic Concerns, Physical Impairment, Disability

Explain if yes: _____

Do you wear any of the following? (Mark all that apply.) Contact lenses Eye glasses Hearing aid(s) Dentures

Orthodontics/braces Limb prosthesis or brace: _____

PAST SURGERIES No previous surgeries

Date: _____ Type: _____ Hospital: _____ Surgeon: _____

Have you ever had a transfusion? No Yes – When: _____

Have you had complications or bad reactions to anesthesia? Mark all that apply:

No past anesthesia problems Never received general anesthesia Difficult intubation Difficult extubation

Malignant hyperthermia Post op nausea/vomiting Local anesthetic resistance Allergic reaction

Difficulty waking up

Sensitivity to anesthesia agent

Medical History (Page 2)

WOMEN ONLY

Are you currently pregnant? Yes No Maybe

Number of pregnancies: _____ Number of natural children: _____ Did you breast feed? Yes No

Number of adopted children: _____ Last menstrual period: _____ Date of last mammogram: _____

Have you had your tubes tied? Yes No Have you had a hysterectomy? Yes No

BIRTH HISTORY – For pediatric patients less than 5 years old only

Birth Weight _____ Hospital _____ Full term Premature (weeks): _____ Overdue (weeks): _____

Mode of delivery Vaginal C-section – Reason: _____ List any problems of pregnancy: _____

Spent time in the NICU? No Yes – Why? _____ Where? _____

INFANT PATIENTS ONLY Mark all that apply. Gastrostomy tube Home oxygen Palatal splint Apnea monitor

Nutrition: Breast milk Formula Baby food Table food Feeding schedule: _____

FAMILY HISTORY Have any blood relatives ever had any of the following?

	Yes	No		Yes	No		Yes	No
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Birth defects	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Cleft lip or palate	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Melanoma	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness/ bipolar	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Sickle cell disease/trait	<input type="checkbox"/>	<input type="checkbox"/>	Mental delay/retardation	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>

List any other serious illness not listed here: _____

Anesthesia problems
 Adopted or family history unknown

SOCIAL HISTORY: ADULT PATIENTS ONLY

Gender: _____ Occupation: _____ Marital Status: _____ Name of Significant Other: _____ Hobbies: _____

Is a responsible adult available to assist during surgery recovery period? Yes No

Do you smoke? No Yes – Cigarettes Cigars Pipes Marijuana How much? _____ packs/day or packs/week

Have you ever smoked? No Yes – Number of years smoked _____ Date quit: _____

Are you aware that smoking increases the risk for surgical complications? No Yes

Do you drink alcohol? No Yes – How much? _____ drinks Daily 2-3 x per week Weekly Occasionally

Do you have a history of drinking to excess? No Yes – Date quit: _____

Do you use any recreational drugs? No Yes – List: _____

SOCIAL HISTORY: PEDIATRIC PATIENTS ONLY

Parents are: Married Never married Divorced Other: _____ Birth Order: _____ Siblings and Ages: _____

Education: Daycare Pre-school Grade School: Level _____ School Name: _____

regular classroom special education home-schooled good student average student learning difficulties

How well does your child get along with his/her teachers and peers? No difficulties Minor difficulties Major difficulties

Has your child been enrolled in any of the following? First Steps Program Speech-Language Therapy – Therapist: _____

Is your child meeting normal growth and developmental milestones? No Yes

Do you have concerns/problems that you would rather discuss when your child is not present? No Yes

Medical History (Page 3)

REVIEW OF SYSTEMS Please mark if you have any of the following:

General Symptoms:

- Fatigue Sleep difficulties Unexplained fevers Loss of appetite
 Unexplained weight loss Recent weight gain

Skin:

- Color changes Previous skin cancer Birthmark Hair loss Excessive sweating Stretch marks

Ears, Nose and Mouth:

- Hearing loss Poor eyesight Nasal obstruction Speech problems
 Dizziness Eye pain Nosebleeds Crowded teeth
 Ringing in ears Sinus infections Cold sores Bleeding gums
 Ear infections Broken nose Hoarseness Toothache

Breast:

- Breast pain Lumps Nipple discharge Dimpling
 Previous biopsy Specialty bras Breast implants Change in size

Lung:

- Chronic cough Pain with deep breathing Bloody sputum
 Recent infection Asthma Pneumonia Shortness of breath

Heart:

- Chest pain Palpitations Heart defect
 Abnormal stress test Lightheadedness/syncope Arrhythmias

Gastrointestinal:

- Abdominal pain Problems swallowing Abnormal stool Nausea/vomiting
 Chronic constipation Jaundice/liver problems Abdominal swelling Abdominal masses
 Acid reflux Hernias Intestinal colic Diarrhea

Genital/urinary:

- Difficulty voiding Frequent urination Incontinence Kidney stones
 Bladder infections Kidney infections Abnormal menstrual periods STD

Musculoskeletal:

- Neck mobility problems Joint pains Weakness Chronic back pain
 Shoulder grooving/pain Scoliosis Torticollis Muscular dystrophy

Neurological:

- Headaches Migraines Previous concussion Convulsions
 Numbness Gait difficulties Memory problems Tremors

Psychological:

- Depression Anxiety Psychiatric illness Bipolar disorder
 Delayed milestones ADD/ADHD Learning disabilities Behavioral issues

Hematology/Oncology:

- History of cancer Radiation Therapy Chemotherapy Easy bruising