

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

No

Preferred 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 \_\_\_\_\_

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

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	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/> 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