Welcome!

Thank you for choosing Dr. Christine Carman Stiles to care for your child's plastic surgery needs.

Plastiks for Kids is located in Suite 225
of the Pediatric Medical Pavilion,
on the southwest corner of Plano Parkway & Marsh
7000 W. Plano Parkway

This is a satellite office of our Frisco practice that focuses on Pediatric Plastic Surgery. All appointments will be at the Plano office on Tuesday mornings. Dr. Stiles operates at the Pediatric Surgery Center, also located at the Pediatric Medical Pavilion.

Thank you for taking the time to download the New Patient paperwork. We ask that you complete this prior to your arrival for the initial appointment. **It is also important to have your pediatrician's information (name & phone number) readily available,** as it is important for Dr. Stiles to have a complete picture of your child's health history.

Your benefits will be verified prior to your initial appointment. We will need for you to bring your current insurance card, as well as a valid driver's license for the responsible party. If your insurance plan requires a referral from your Primary Care Physician, please obtain this before your appointment. **The appointment will be rescheduled if the referral is not received by the initial visit.** You may bring this to your appointment or have it faxed to our office at 214-618-6203.

We would like to make this the most pleasant medical experience for you and your child. **In order to keep the clinic on schedule, it may be necessary to reschedule your child's appointment if you are not able to make the scheduled appointment time.** We ask for your cooperation by completing all paperwork ahead of time and bringing any relevant information regarding your child's condition.

Please feel free to call our office at 214-618-4000 if you have any questions or concerns. We look forward to seeing you!

W Parker Rd

Park in front
of the
Pediatric Surgery
Center

The office is on the
2nd floor of this building

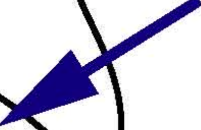
W Plano Pkwy

Midway Road

Dallas North Tollway

Plastiks
for kids
Suite 225

On Plano
Parkway and
Marsh Lane



Marsh Ln

The Shops
at Willow
Bend

Hebron Pkwy / W Park Blvd

Minor Patient Information

Name:_______________________________________

Address:_____________________________________

City:________________ State:_____ Zip:_________

Home Phone:__________________________________

Date of Birth:_____________Sex:_________

Social Security Number:_______-________-_________

Student: Y N

Parent / Guardian Information

Mother's Name: ________________________________

Work Phone:__________________________________

Cell Phone: ___________________________________

Father's Name:_________________________________

Work Phone:__________________________________

Cell Phone: ___________________________________

In Case of Emergency (someone not living with the patient)

Name:_______________________________________
Phone:______________________
Relationship:___________

Reason for Consultation

____

____

Whom May We Thank for Referring You?

Name:_______________________________________
Address:_____________________________________
City:________________ State:______ Zip:_________
Phone:______________________
Relationship:___________
Other: Newspaper_____ Staff ___ Yellow Pages ____
Other ______________

Pediatrician/Primary Care Physician

Name:_______________________________________

Address:_____________________________________

City:______________________ State:______

Zip:__________Phone:__________________________

Insured/Responsible Party

Insured's Name:_______________________________

Relationship to Patient:_________________________

Address:_____________________________________

City:_________________ State:______ Zip:_________

Home Phone:__________________________________

Work Phone:__________________________________

Date of Birth:_________Sex:___Marital Status:_______

Social Security Number :_________-______-________

Employer:____________________________________

Insurance Carrier:______________________________

Insurance Phone Number:________________________

Policy #:____________________Group #:___________

Is this Plan a: PPO______ POS______ HMO________

Are Referrals Required? _____ Are we in network?____

Preferred Method of Contact: ___________________

Email Address: _______________________________

I certify the above information is correct to the best of my knowledge. I understand that I am financially responsible for all charges whether or not covered by insurance. I also have received a Notice of Privacy Practices and Disclosure of Investment from Plastiks for Kids.

Signature:___________________________

Date:_______________________________

Patient Name:

PATIENT MEDICAL HISTORY (PEDIATRIC)

PREGNANCY, BIRTH, & INFANT HEALTH HISTORY ***YES*** ***NO***

1. Did you have any illness or problems during your pregnancy? ____________________________
2. Were there any problems with delivery? ____________________________
3. Was the delivery by C-Section? ____________________________
4. Did your baby have any trouble breathing after delivery? ____________________________
5. What was the birth weight ____________ lbs ___________oz.
6. Did your child have any health or feeding trouble during the first 2-3 months? ____________________________
7. As an infant, did your child have difficulty with weight gain? ____________________________
8. Has your child had any infections? ____________________________

GENERAL HEALTH & HISTORY DEVELOPMENT

1. *Does your child have ALLERGIES to food or drugs?* ____________________________
   If so, please name them: ____
2. *List all MEDICATIONS and DOSAGE your child is taking or has taken* ________________________________
   ____
   ____
3. Has your child had any of the following?
   - ☐ *Heart Defects* ☐ *Kidney Disease* ☐ *Hepatitis* ☐ *Pneumonia* ☐ *Meningitis*
   - ☐ *Broken Bones* ☐ *Serious Accidents* ☐ *Cancer* ☐ *Tonsils & Adenoids Removed*

   Other Diseases or conditions
   ____
   ____
   Handicaps ____
4. *Does your child have now, or had in the past, any of the following:* *Yes* *No*
   - *Frequent ear infections?* ________________________________
   - *5 or more colds/throat infections in the past year?* ________________________________
   - *Convulsions or seizures?* ________________________________
   - *Trouble with hearing?* ________________________________
   - *Dental Problems?* ________________________________
5. *Is your child current on all immunizations:* ________________________________
6. *Hospitalizations for surgeries other than those performed by our physicians:*
   *Age*______ *Date*___________ *Illness or Operation/Physician*____
   *Age*______ *Date*___________ *Illness or Operation/Physician*____
   Age______ Date___________ Illness or Operation/Physician____

FAMILY HISTORY

1. Is your child adopted? Yes ___________ No ___________
2. Do the child's parents have any health problems? Yes ___________ No ___________
7. Please check any of the following diseases or conditions the child's parents, grandparents, aunts, uncles, brothers, or sisters may have had:
   - ☐ Seizures ☐ Cancer ☐ Blood Diseases ☐ Nervous Breakdown
   - ☐ Asthma ☐ Allergy ☐ Diabetes ☐ Inherited/Family diseases
   - ☐ Ulcers ☐ Tuberculosis ☐ Anesthesia Problems ☐ Learning Problems
   - ☐ Hepatitis

SIGNATURE:____
DATE:_________________________

Financial Policy

We are committed to providing you with the best possible health care, and we are pleased to discuss our professional fees with you at any time. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policies. Please ask if you have any questions about our fees, your responsibility, or the financial policy.

All patients must complete our Patient Information Form and inform our office of any changes in address or insurance. In order for us to treat and care for our patients, we must have complete and correct information.

Payment for services rendered is ***due at the time of service***. We accept cash, check, MasterCard, Visa, Discover, and American Express. There will be a $25.00 service charge for any returned checks.

We expect TOTAL PAYMENT two weeks prior to all aesthetic procedures unless you have been pre-approved with one of our financial plans.

The charges on your account with our office will reflect ***our*** doctor's fees only, *unless otherwise noted*. Any hospital, x-ray, laboratory, anesthesia, pathology, etc. will be billed by the provider performing the service.

Insurance policy:
We will gladly answer questions regarding your insurance. If the proposed services are medically necessary, we will attempt authorization from your insurance company. You must realize, however, that:

- Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
- Not all services are a covered benefit in your contract. Some insurance companies arbitrarily select certain services they will not cover and these are a patient responsibility.
- If your insurance coverage is through a plan that we are ***not*** contracted with, regardless of your carrier's rate of reimbursement, you will be responsible for the **FULL** balance of your account. This includes any amount over the "reasonable and customary".

We must emphasize that as a medical care provider, the relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. It is understood that temporary financial problems may affect timely payment of your account. If such problems arise, you are encouraged to contact us promptly for assistance in the management of your account.

"I hereby assign, transfer, and set over to The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy with my current insurance company."

_________***Initials***

As part of your treatment, we require both before and after treatment photographs for which the fees are included in our charges.

If at any time after your initial surgery you feel that you need a revision surgery, facility and anesthesia fees will be applicable. Surgeons' fees are at the discretion of your surgeon.

"I authorize The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids and personnel of their choosing to photograph me prior to, during, and following any surgery. I understand these photographs will be a part of my medical records and are vital to my quality of care and post surgical result."

Signature:____ Date;________________________________

Photography Release

Dated: ___________________________

I, _____________________________________(patient's name) hereby give The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids the absolute and irrevocable right and permission, with respect to photographs they have taken of me and/or in which I may be included with others:

a. To copyright the same in their own name or any other name they may choose.
b. To use, re-use, publish and/or re-publish the same in whole or in part, individually, or in conjunction with other photographs, in any medium and for any purpose whatsoever, including (but not limited to) illustration, promotion and/or advertising and/or trade.
c. To use my name in connection therewith if they so choose.

I hereby release and discharge The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids from any and all claims and demands arising out of or in connection with the use of the photographs, including any and all claims for libel.

This authorization and release shall also ensure to the benefit of the legal representatives, licensees, and assignees of The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids as well as the person(s) for whom they took the photographs.

I have read the foregoing and fully understand the contents thereof.

____
(patient signature or legal guardian if minor)

____
(witness signature)

____
(legal guardian relationship to patient if minor)

____
(patient address)

____

The Center for Breast & Body Contouring, P.A.
5575 Warren Parkway, Suite 304, Frisco, Texas 75034

Plastiks for Kids
7000 W. Plano Parkway, Suite 225, Plano, Texas 75093

ph: 214-618-4000 **fax: 214-618-6203**