2800 Ross Clark Circle, Suite 2
Dothan, Alabama 36301
334-699-7477

Patient Information

Patient Name: ______________________ Today's Date: ______________
Street Address: ______________________ Apt, Lot, Ste #: ______________
City: ______________________ State: __________ Zip: __________
DOB: __________ Race: _____ Age: _____ Sex: _____ Marital Status: ☐ M ☐ S ☐ D ☐ W
Home Phone #: ______________________ Cell Phone #: ______________________
Employer: ______________________ Work #: ______________________
May we contact you at work? __________ Do you wish phone calls to be confidential? __________
Email: ______________________ May we send information here? __________
SSN: ______________ How did you hear about our practice? ______________
Referring Physician (if applicable): ______________________________
Primary Care Physician: ______________________________

Emergency Contact Information

Contact Name: ______________________ Relationship to Patient: ______________
Contact Number: ______________________ Alternate number: ______________________

Insurance Information

Primary Insurance

Insurance Company: ______________________ Policy ID Number: ______________________
Cardholder's Name: ______________________ Relationship to Patient: ______________
Cardholder's DOB: ______________________ Cardholder's SSN: ______________________
Cardholder's Employer: ______________________________

Secondary Insurance

Insurance Company: ______________________ Policy ID Number: ______________________
Cardholder's Name: ______________________ Relationship to Patient: ______________
Cardholder's DOB: ______________________ Cardholder's SSN: ______________________
Cardholder's Employer: ______________________________

I authorize payment of benefits as determined by my insurance carrier directly to the physician. As the responsible party, I agree that I will be responsible for all charges incurred including those amounts not paid by my insurance company. Also, I agree that to my knowledge the above information is the most accurate and up to date. I authorize the release of this Information as well as the release of medical records, If necessary, for payment by my insurance carrier. I authorize the use of this signature on all of my insurance submissions whether manual or electronic. I understand I will be charged for, and hereby agree to pay, all costs and expenses incurred in collection, any past due fees, and interest allowed by law, all without relief from valuation and appraisement laws.

Please note, there may be additional costs from outside laboratories. Biopsies, cultures, and other medical specimens will be sent to an outside lab. It is the patient's responsibility to contact their insurance carrier with inquires regarding network coverage for these facilities. Information on these facilities will gladly be supplied to the patient at their request.

Responsible Party Signature: ______________________ Date: ______________

SOUTHERN
INSTITUTE OF PLASTIC SURGERY

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Dothan, Alabama 36301
334-699-7477

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that under the HIPAA (Health Insurance Portability and Accountability Act of 1996), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

By signing below, I understand the Privacy Practices from Southern Institute of Plastic Surgery.

______________________________ __________________
Patient Signature Date

______________________________ __________________
Witness Signature Date

Documentation of Failure to Obtain Signed Acknowledgement

On ________________, I ____________________________ an employee of Southern Institute of Plastic Surgery presented this Acknowledgement of Receipt of Notice of Privacy Practices form to patient ____________________________. The patient refused to provide a signature when requested.

ePRESCRIBING CONSENT

ePrescribing is a federally mandated initiative that requires all physicians to prescribe in this manner. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, utilizing secure technology to protect the privacy of your personal information. ePrescribing software also allows us to see important information such as drug interactions and your prescription history. The benefit to you is less confusion over handwritten prescriptions or unclear phone calls, reduced possibility of medical errors, fewer trips to drop off prescriptions at the pharmacy, and a safer, faster, easier way to get your prescription filled.

______________________________ __________________
Patient Signature Date

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Authorization for Verbal Release of Protected Health Information

STANDARD DISCLOSURE

I authorize Southern Institute of Plastic Surgery to discuss my medical history, diagnosis, treatment, prognosis, and financial, insurance and billing information with those listed below. I understand this may include information regarding testing, examination and treatment for HIV, AIDS related illness, mental health and drug, alcohol or chemical abuse, as well as, confirmation of any appointment for me to be seen in the office, hospital or other physicians
office.

☐ Spouse: ______________________________

☐ Children: ______________________________

☐ Parent(s): ______________________________

☐ Other: ______________________________

☐ NO INFORMATION

I do not authorize release of any verbal information concerning my treatment. I understand that this includes confirmation of appointment dates, times, location and any billing or financial information.

I consent and authorize the release of any test results to be left on my voice mail at

☐ Home ☐ Cell ☐ Work number ☐ Other______________ This authorization will expire at the end of my treatment with Southern Institute of Plastic Surgery unless I revoke the consent prior to that time.

______________________________ ______________

Signature of Patient Date

______________________________ ______________

Witness Date

Patient Name: ______________________________ DOB: ________________

Preferred pharmacy: ____________________________

Past Medical History (please circle all that apply)

Alzheimer's/Dementia
Adrenal hypofunction
Adverse anesthesia outcome
Anxiety
Arthritis
Asthma
Atrial fibrillation
Autoimmune disease
Benign prostatic hyperplasia (BP
Bipolar disorder
History of stroke
COPD

Coronary artery disease
DVT
Depression
Diabetes
Elevated blood pressure
End-stage kidney failure
Epilepsy
Gastric reflux (GERD)
Hearing loss
Heart valve disorder
HIV
High cholesterol

Overactive thyroid
Underactive thyroid
Hepatits:
A B C
Kidney disease
Malignancy of :
Breast
Colon
Lung
Prostate

Lupus
Lymphoma
Neuromuscular disorder
Pneumothorax
Pulmonary embolism
Seizures
List any condition not found above:
____
____

Past Surgical History (please circle all that apply)

Appendectomy
Colon resection
Cesarean section
Colostomy/ Colectomy
Coronary Bypass
Transplant of:
kidney
lung
heart
other: ________

Gallbladder removal
Gastrostomy
Spinal surgery
Tubal ligation
Mastectomy
Kidney stone removal
Heart valve replaced:
Cadaver
Artificial
Lumpectomy

Removal of :
Bladder
Liver
Lung
Kidney
Ovaries
Spleen
Pancreas
Prostate

Joint relplacement of:
Knee
right left both
Hip
right left both
List any procedures not found above:
____
____

Skin Disease History (please circle all that apply)

Acne
Actinic Keratoses
Basal Cell Carcinoma

Eczema
Hay Fever/ Allergies
Melanoma

Dysplastic moles
Psoriasis
Squamous Cell Carcinoma

Do you tan in a tanning salon? No Yes
Do you wear sunscreen daily? No Yes If yes, what SPF? ________
Do you have a family history of melanoma? No Yes

Plastic Surgery History (please circle all that apply)

Abdominoplasty
Chin augmentation
Breast augmentation
Blepharoplasty (lower)
Blepharoplasty (upper)
Brow lift
Correction of inverted nipple
Facelift
Hair transplant

Laser resurfacing
Nasal fracture repair
Otoplasty
Reconstruction due to skin cancer surgery
Reconstruction following trauma
Reduction, breast
Removal of implants
Repair of cleft lip/palate
Repair of earlobe

List any procedures not found above:
____
____
____

Do you have a family history of breast cancer?
If yes, which relative ____________________

Do you have a family history of malignant hyperthermial or anesthesia sensitivity
If yes, which relative ____________________

Medications

Name	Strength	Frequency

(you may attach a list if necessary)

Allergies

Name	Reaction

Social History

Nicotine Use

- Never used
- Formerly used
- Currently use:
  - Cigarettes
  - E-cigs/vapes
  - Smokeless tobacco

Alcohol use:

- None
- Less than 1 drink per day
- 1-2 drinks per day
- 3 or more drinks per day

How many times in the past year have you had 4 or more drinks in one sitting? ___________

Family History (only list medical conditions of 1st degree relatives: parents, siblings, and/or children)

____

____

Are you currenly experiencing any of the following? (please circle all that apply)

Vision problems	Throat discomfort	Heart skipping	Allergy to topical antibiotics
Problems with bleeding	Nasal obstruction	Cough	Artificail heart valve
Nose bleeds	Blurry vision	Shortness of breath	Artificial joint within the last 2 years
Problems with healing	Abdominal pain	Problems with snoring	Blood thinner use
Problems with scarring	Nausea/vomitting	Bleeds easily	Defibrilator
Rash	Bruise easily	Difficulty with body image	History of MRSA
Immunosuppression	Headaches	Anorexia	Pacemaker
Chest pain	Seizures	Bulimia	Require antibiotics prior to procedures
Fever or chills	Facial weakness	Allergy to adhesive	Pregnant or planning to become pregnant
Unintentional weight loss	Facial numbness	Allergy to lidocaine	Breastfeeding
Eye pain			

Complete only if aged 60+

Have you recieved the pneumonia vaccine? No Yes

Do you have a living will? No Yes

If yes, do you have a health care proxy listed to make medical decisions on your behalf if you are unable?

If yes, Proxy's name and number: ______________________________

Which statement best reflects your wishes on advanced care?

___ **Full Cardiopulmonary Resuscitation**

___ **Do Not Resuscitate**

___ **Do Not Intubate**