SOUTHERN
INSTITUTE OF PLASTIC SURGERY

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:** _____

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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

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Patient Name _____

Date of Birth _____

Primary Care Physician _____

Influenza Vaccine

Check the one that fits best:

_____ Received a flu vaccine this flu season.
_____ Did not receive a flu vaccine this flu season because of medical reasons.
_____ Did not receive a flu vaccine this flu season because I don't want one.

Pneumococcal Vaccine

_____ Received a Pneumococcal Vaccine (Pneumovax) within the last year.
_____ Did not receive a Pneumococcal Vaccine.

Advanced Directives

Advance Directives are designed to respect your wishes about life-saving medical treatment if you are unconscious or incapacitated.

Which statement(s) best reflect your wishes on advanced care recommendations?

_____ **Full Cardiopulmonary Resuscitation:** I want full cardiopulmonary resuscitation (CPR) efforts to be made (full code).
_____ **Do Not Resuscitate:** If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life.
_____ **Do Not Intubate:** I do not wish to have a breathing tube inserted, even if it is necessary to save my life.

Do you have a living will? _____

If yes, do you have a health care proxy named in the event you are unable to make your own medical decisions? _____

If yes, Proxy's name _____ Proxy's phone number _____

Patient signature _____ Date _____

Name _____

Past Medical History (please circle all that apply)

Alzheimer's/Dementia
Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
Benign Prostatic Hyperplasia
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
Acid Reflux
Hearing Loss
Heart Attack
Hepatitis (Type: A, B, C)
High Blood Pressure
HIV/AIDS
High Cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pulmonary Embolism
Prostate Cancer
Radiation Treatment
Seizures
Stroke
None
List any condition not found above
_____
_____
_____

Past Surgical History (please circle all that apply)

Appendix Removed
Urinary Bladder Removed
Mastectomy (Right, Left, Both)
Breast Lumpectomy (Right, Left, Both)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Colon: Colostomy (Surgical Colon Bypass)
Gallbladder Removed
Biological Valve Replacement
Coronary Artery Bypass
Heart Transplant
Mechanical Valve Transplant
Heart: Coronary Angioplasty
Joint Replacement Hip (Right, Left, Both)
Joint Replacement Knee (Right, Left, Both)
Kidney Biopsy
Kidney Stone Removal
Kidney Transplant
Kidney Removed (Right, Left)
Liver Removed
Liver Transplant
Liver Shunt
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries: Tubal Ligation
Pancreas Removed
Prostate Biopsy
Prostate Removed: Prostate Cancer
TURP: Prostate Resection
Rectum: Repair
Rectum: Resection
Spleen Removed
Testicles Removed (Right, Left, Both)
Hysterectomy: Cervical Cancer
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
List any surgery not found above
_____
_____
_____

Skin Disease History (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburn
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/ Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None
List any condition not found above
_____
_____
_____

Do you tan in a tanning salon? Yes No

Do you wear sunscreen daily? Yes No If yes, what SPF? _____

Family history of Melanoma? Yes No If yes, which relative? _____

Pharmacy for us to send your prescription

Pharmacy name _____ Zip Code _____

Turn page over to complete history

Medications (i.e. Simvastatin 20 mg by mouth 1 tablet daily, you may also attach a med list if needed)

_____

_____

_____

_____

_____

Allergies (please list all allergic reactions)

_____

_____

Social History (please circle all that apply)

Cigarette Smoking

Never Smoked
Former Smoker
Current Smoker

Alcohol Use

Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

*Males under 65: How many times in the past year have you had 5 or more drinks in one sitting? _____
*Females and Males over 65: How many times in the past year have you had 4 or more drinks in one sitting? _____

Family Medical History (only list medical conditions of first degree relatives such as parents, siblings, and/or children)

_____

_____

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

Problems with Bleeding
Problems with Healing
Problems with Scarring
Rash
Immunosuppression
Hay Fever
Chest Pain
Fever or Chills
Night Sweats
Unintentional Weight Loss
Thyroid Problems
Blurry Vision
Abdominal Pain
Bloody Stool
Bloody Urine
Joint Aches
Muscles Weakness
Headaches
Seizures
Cough
Shortness of Breath
Anxiety
Depression

Allergy to Adhesive
Allergy to Lidocaine
Allergy to Topical Antibiotics
Artificial Heart Valve
Artificial Joint Replacement within the last two years
Blood Thinners
Defibrillator
MRSA infection
Pacemaker
Require Antibiotics Prior to Surgical Procedures
Rapid Heart Beat with Epinephrine
Are You Pregnant?
Currently Trying to Get Pregnant?