ASSOCIATES IN

PLASTIC SURGERY

EST. 1978

Patient Name_____

Date of Birth_____ Gender □ M □ F Social Security Number _____ - _____ - _____

Address_____

City_____State_____Zip_____

Email_____

Home#_____Work#_____Cell#_____

Employed by_____Occupation _____

Emergency Contact_____Phone#_____

Responsible party if patient is a minor_____□Parent □Guardian

Name of Primary Insurance Company_____

Policy Holder's Name_____Relationship to patient _____

Name of Secondary Insurance Company _____

Policy Holder's Name_____Relationship to patient _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and agree to pay for all charges for such treatment. **WE REQUIRE THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.**

I agree that this office will prepare and file any insurance claim which I have in connection with treatment received, and I agree, as evidenced by my signature, to assign payment of any applicable benefits payable to my insurance company to this office. A copy of this agreement will be considered as valid as an original. I also authorize the release of all information necessary to secure payment of my claim.

I understand the practice is not responsible for collecting payment from my insurance company. If the company delays or withholds payment of my claim, I will be responsible for direct payment. I am also responsible for all amounts which the insurance does not pay, including any deductible amounts, coinsurance or charges not covered. I understand and agree that a service charge in the amount of 1.5% (one- and one-half percent) or 18% per annum will be assessed on the unpaid balance after 90 days from the date of service. If it becomes necessary to refer this account to an attorney or collection agency for collection, I am responsible to pay all reasonable collection agency and/or attorney fees and court costs.

I agree to be photographed before and after my surgical procedure and understand these photographs will remain the property of my treating physician.

DATE_____SIGNATURE_____

Patient, Parent, or Legal Guardian

Est.1978

Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff of Associates in Plastic Surgery, to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices for Associates in Plastic Surgery.

Name and relationship of the person you wish to allow access – for example, your spouse, child, sibling, neighbor, caretaker, clergy, or close friend:

Name of Person or Entity	**Relationship**

This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me.

I understand that information used or disclosed pursuant to this authorization may be disclosed by Associates in Plastic Surgery and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at Associates in Plastic Surgery. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information to obtain payment from my health insurance company.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

Date

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices of Associates in Plastic Surgery.

Signed:_____ Date:_____ Print Name:_____ Telephone:_____

If not signed by the patient, please indicate relationship and describe authority to act:

☐ parent or guardian of minor patient ☐ beneficiary or personal representative of deceased patient
☐ guardian or conservator of an incompetent patient

MEDICAL / SURGICAL HISTORY

Patient Name: _____ Today's Date: _____

Patient Date of Birth: _____ Surgeon Name: Riley Dean M.D.

In this time of rapidly expanding medical knowledge and the increasing specialization associated therewith, there exists a very real risk of the specialist physician not being aware of the general health and medical background of the patient. On occasion such information may critically affect what procedures we may safely undertake on you and under what circumstances. We therefore ask that you give us the following medical information.

Age: Height: Weight: Occupation:
Please list all medications which you are currently taking or have used in the past 6 months. (Be sure to include any of the following: birth control, aspirin or ibuprofen containing drugs, diet pills, GLP1, diabetic medications, steroids, glaucoma drops, asthma medications, Digoxin, Lanoxin, Nitroglycerin, Isordil, Inderal, other heart medications, Lasix, other diuretics, high blood pressure medications, Coumadin, Persantine, Tranquillizers, Sleeping pills, anti- depressants, pain pills, or shots, epilepsy medications).
Medication(s): Amount: Frequency:
List all drug allergies:
Do you use nicotine products? YES / NO How often are (were) you using nicotine products?
In the past 90 days have you used (circle): LSD / speed / cocaine / Marijuana?
How much alcohol do you drink? Caffeine?
Please Circle all of the following medical conditions you now have or have had in the past: High blood pressure / bleeding tendency / deep venous thrombosis / hepatitis / diabetes / blood transfusion/ glaucoma / dry eyes / lung disease / TB / asthma or wheezing / emphysema / bronchitis / chest pain / irregular heart beat / heart disease / heart attack / stroke / epilepsy / heart burn / depression / mental illness / ulcers or bleeding / drug or alcohol addictions / obstructive sleep apnea with or without CPAP machine / **OTHER:**
Could you be pregnant at this time? YES / NO Are you currently breast feeding? YES / NO
List all surgeries that you have had (include plastic surgery):
Have you or anyone in your family ever had unusual reactions to anesthesia (muscle weakness, jaundice, breathing problems or unexpected fevers? YES / NO
Do you have (circle): loose or chipped teeth / caps / dentures / contact lenses / None
Have you ever seen a cardiologist? YES / NO Do you see any other specialists? YES / NO
Date of last EKG: Date of last mammogram:

Patients signature:
Date:

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BREAST REDUCTION EVALUATION

THIS EVALUATION IS REQUIRED BY YOUR INSURANCE COMPANY. FAILURE TO COMPLETE THIS EVALUATION FORM MAY DELAY A RESPONSE FROM YOUR INSURANCE COMPANY.

Name: _____

Appointment Date: _____

Age: _____ Height: _____ Weight: _____

Recent weight loss: Yes/No If yes, how much?_____

Referring Physician (if applicable) _____

Current bra size: _____

Family history of breast cancer: Yes/No

Bra size you would like to be: _____

Personal history of breast problems: Yes/No

Date of last mammogram: _____

If yes, please explain:

_____

Facility of last mammogram: _____

Ovarian Cancer: Yes/No

Mammogram normal: Yes/No

Please check the following that apply due to excess breast weight:

- ☐ Neck and back pain/strain during daily activities
- ☐ Difficulty with exercise
- ☐ Poor posture
- ☐ Shoulder bra strap grooving
- ☐ Difficulty sleeping
- ☐ Headaches
- ☐ Skin rashes/infections under breasts
- ☐ Have experienced any of the above symptoms for 3 or more years

Have you seen another doctor for any of these symptoms? Yes/No Who? _____

If yes, what treatment and/or medication was prescribed: _____

Have you tried any of the following to treat your symptoms? (Please check all that apply)

- ☐ Ibuprofen/Advil/Motrin/Aleve
- ☐ Powders and/or creams
- ☐ Proper support garments (different bras, larger bra straps, etc.)
- ☐ Massage Therapy
- ☐ Chiropractic care
- ☐ Cold/Heat Therapy
- ☐ Physical therapy and/or exercises
- ☐ Tried any of these treatments for 6 months or more

TO BE COMPLETED BY OFFICE STAFF

Sternal notch to nipple measurement R _____ L _____

Estimated gram amount to be removed R _____ L _____

Associates in Plastic Surgery Website Photo Release

Our office is currently updating our website. Patients considering surgery have expressed their desire to see photos on our website. I think that you have a wonderful result from your surgery, and would like to use your before and after photos on our website.

Please sign below if you authorize use of your before and after photos on our website.

Print Name _____ Date of Birth _____

Signature _____ Date _____