- ❑ Dr. Smith
- ❑ Dr. Greco
- ❑ Dr. Dascombe
- ❑ Dr. Paletta
- ❑ Dr. Most

The Georgia Institute For Plastic Surgery

PATIENT INFORMATION SHEET

- ❑ Single
- ❑ Married
- ❑ Widowed
- ❑ Divorced
- ❑ Separated

Have you ever been seen by one of our doctors? ❑ No ❑ Yes, in what year?____________________________

Patient Legal Name____ Nickname ______________
Last First Initial

Sex________ Date of Birth____________________ Age__________ Social Security #__________________________

Home Address____
Street City State Zip

Home Phone#_________________________Cell / Alternate Phone#____

Employer____ Work Phone #_____________________

Name of Closest Relative, Friend or Neighbor________________________________ Phone #_________________

Patient Primary Care Physician ____ Phone #____________________

Referred by Dr.__________________________ ❑Phone Book ❑Radio ❑Postcard ❑Web ❑Other

Specific Reason for Visit____

Required Information

Email Address____________________________________/May we contact you through email ❑Yes ❑No

Would you like to receive our quarterly newsletter through E-zine? ❑Yes ❑No

****

Name of Responsible Party, if other than patient____
Last First Initial

Home Address if different from above____
Street City State Zip

Home Phone #_________________________________Cell/Alternate Phone#_______________________________

Employer____ Work Phone #_____________________

****

I, _______________________________________, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and the treatment by my doctor and such assistant or staff as may be assigned by him/her.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of any medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. In the event of any litigation arising from treatment. I agree to submit the case to arbitration. I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize the taking of photographs at the direction of my surgeon and under such conditions as may be approved by him/her. These photographs will be used solely for documentation purposes and will be kept confidential.

I understand that there may be a consultation fee for the initial visit which is due at the time of my appointment unless other arrangements have been made in advance.

SIGNATURE: _________________________________ DATE:_____________________________

RELATIONSHIP: (Circle one) PATIENT SPOUSE PARENT GUARDIAN

1046

MEDICAL AND SURGICAL HISTORY

Name: ______________________________ Age: ________ Height: ________ Weight: ________
Occupation: ______________________________ Current Physician: ______________________________

♦ PERSONAL MEDICAL HISTORY

Medical Allergies: ______________________________

Please list all medications you are currently taking, including vitamins, birth control pills, aspirin, diet pills, herbal supplements, and any health food store over the counter supplements.

____

____

Exercise regularly? YES/NO What exercise do you do? ______________________________
Any chance that you may be pregnant? YES/NO Date of your last menstrual period? ____________
Are you a smoker? YES/NO < 1ppd 1ppd 2ppd Ex-smoker? YES/NO When? ____________
How much alcohol do you drink? ______________________________
Have you ever used (circle): LSD / speed / cocaine / marijuana Never

♦ FAMILY HISTORY

Have you or anyone in your family ever had problems with anesthesia? YES/NO
Who? What happened? ______________________________
Any Family History of Heart Disease Lung Disease Other
Describe ______________________________

♦ PERSONAL SURGICAL HISTORY

Please list all surgeries or hospitalizations you have had (including plastic surgery).

	Date

Do you have or have you had any of the following?

	YES	NO	YEAR		YES	NO	YEAR
Heart Attack				Bleeding tendency			
High Blood Pressure				Depression			
Irregular Heartbeat				Mental Illness			
Chest Pain (angina)				Seizures			
Abnormal EKG				AIDS/HIV positive			
Mitral Valve Prolapse				Blood Clots in legs / lungs			
Asthma or wheezing				Dry eyes			
Bronchitis				Glaucoma			
Emphysema				Steroid treatment			
Shortness of Breath				Other (please describe)			
Diabetes							
Kidney problems							
Liver disease (hepatitis)							
Heart burn or reflux							

Patient Signature: ______________________________ Date: ____________________

INSURANCE INFORMATION

Please fill out all of the appropriate information

PRIVATE INSURANCE - Primary

Policy Holders Name___________________________

Policy Holders SSN#___________________ Sex___________ DOB___________

Policy Holders Employer___________________________

Patient's Relationship to Policy Holder ❑Self ❑Spouse ❑Child ❑Other Effective date of Coverage___________

ID/Policy #___________________ Group No.___________________

Name of Insurance Company___________________________

PRIVATE INSURANCE - Secondary

Policy Holders Name___________________________

Policy Holders SSN#___________________ Sex___________ DOB___________

Policy Holders Employer___________________________

Patient's Relationship to Policy Holder ❑Self ❑Spouse ❑Child ❑Other Effective date of Coverage___________

ID/Policy #___________________ Group No.___________________

Name of Insurance Company___________________________

PRIVATE INSURANCE - Other

Policy Holders Name___________________________

Policy Holders SSN#___________________ Sex___________ DOB___________

Policy Holders Employer___________________________

Patient's Relationship to Policy Holder ❑Self ❑Spouse ❑Child ❑Other Effective date of Coverage___________

ID/Policy #___________________ Group No.___________________

Name of Insurance Company___________________________

ACCIDENTS-Auto-Other

If your injury is a result of an auto accident, please fill out this section

Policy Holders Name___________________________

Policy Holders Address___________________________

Auto Insurance Co. Name___________________ Policy No.___________

Insurance Co. Address___________________ Date Accident Occurred___________

How Did Accident Occur?___________________________

____

Attorney's Name___________________ Address___________________

WORKMEN'S COMPENSATION

If your injury is a result of an accident that occurred on the job, please fill out this section

Employer___________________________

Employer's Address___________________________

Date of Injury___________________ Was Injury Reported to Employer? Yes_____ No_____

Tell us how injury occurred___________________________

____

____

____

____

Signature ___________________ **Date** ___________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*This is an acknowledgement of receipt only.

I have received a copy of the Notice of Privacy Practices for The Georgia Institute For Plastic Surgery.

____
Name of Patient (Print or Type)

____
Signature of Patient

____
Date

____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

____
Relationship of Patient Representative to Patient

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1. Can we call you at home? Yes or No
2. Can we leave a message for you at home? Yes or No
3. Can we leave a message for you at work? Yes or No
4. With whom may we discuss your medical condition:

    1. ____________________________________

    2. ____________________________________

The Georgia Institute For Plastic Surgery / The Plastic Surgery Center L.L.C.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY

Uses and Disclosures

Treatment - Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment - Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive infromation on dates of service, the services provided, and the medical condition being treated.

Health care operations - Your health information may be used as necessary to support the day-to-day activities and management of The Georgia Institute For Plastic Surgery. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement - Your health information may be disclosed to law enforcement agencies to support government audits and inspectors, to facilitate law enforcement investigations, and to comply with government-mandated reporting.

Public health reporting - Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occured before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders - Your health information may be used by our staff to send you appointment reminders.

Information about treatments - Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your private health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

The Georgia Institute For Plastic Surgery duties:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Medical Records Clerk or the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints and Contact Person

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
The Georgia Institute For Plastic Surgery
5361 Reynolds Street
Savannah, GA 31405
(912) 355-8000

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date

This notice is effective on or after April 14, 2003.