

THE GEORGIA INSTITUTE FOR PLASTIC SURGERY / PLASTIC SURGERY CENTER LAND, L.L.C.

5361 Reynolds Street • Savannah, GA 31405

Phone-(912) 355-8000 • Fax-(912) 356-0229

Patient Registration Form

Patient Information	Legal Name (Last, First, MI)			Suffix:	Preferred Name:	
	Date of Birth:	Age:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Partner <input type="checkbox"/> Other			
	Street Address:			City:	State:	Zip Code:
	Home Phone: () Preferred <input type="checkbox"/>		Work Phone: () Preferred <input type="checkbox"/>		Cell Phone: () Preferred <input type="checkbox"/>	
	Email Address:		May we contact you through Email? <input type="checkbox"/> YES <input type="checkbox"/> NO		Would you like to receive our Quarterly Newsletter through Email? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	Identified Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN:	Referring Physician:		Primary Care Physician:	
	Preferred Language:		Race:		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic <input type="checkbox"/> Unknown	
	Does Patient Live in a Nursing Home or Assisted Living Facility? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, what is the Name of the Facility?					
Financially Responsible Party	Name of Responsible Party, if other than patient:					
	Name:	Address:		City/State/Zip	Relationship to Patient:	
	Occupation:	Employer:		Email Address:	Date of Birth:	
	Home Phone: () Preferred <input type="checkbox"/>		Work Phone: () Preferred <input type="checkbox"/>		Cell Phone: () Preferred <input type="checkbox"/>	
Emergency Contact	Name:			Relationship to Patient:		
	Home Phone: () Preferred <input type="checkbox"/>		Work Phone: () Preferred <input type="checkbox"/>		Cell Phone: () Preferred <input type="checkbox"/>	
Insurance Information	PRIMARY Insurance Carrier:		Policy Number:		Group Number:	
	Patient's Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if other than Patient):		
	Subscriber's Social Security #:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Subscriber's Employer:	Work Phone: ()	
	SECONDARY Insurance Carrier:		Policy Number:		Group Number:	
	Patient's Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if other than Patient):		
	Subscriber's Social Security #:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Subscriber's Employer:	Work Phone: ()	
Medicare	IF YOU HAVE MEDICARE COVERAGE OR ARE ELIGIBLE FOR MEDICARE COVERAGE, PLEASE COMPLETE THE QUESTIONS BELOW:					
	Are you still working? <input type="checkbox"/> YES <input type="checkbox"/> NO Retirement Date: _____ Do you have an Employer Group Health Coverage Plan? <input type="checkbox"/> YES <input type="checkbox"/> NO Is your Spouse still working? <input type="checkbox"/> YES <input type="checkbox"/> NO Retirement Date: _____ Are you covered through your Spouse's Insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO					
<p>By Signing Below, I acknowledge that the information I have provided is correct to the best of my ability.</p> Patient Signature: _____ Date: ____/____/_____ Guarantor Signature (if other than patient): _____ Date: ____/____/_____ 						

The Georgia Institute For Plastic Surgery/The Plastic Surgery Center Land, LLC
Patient Record Of Disclosures

In general, HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner:

- Home Phone** - It is ok to leave a message with detailed information.
- Cell Phone** - It is ok to leave a message with detailed information.
- Work Phone** - It is ok to leave a message with detailed information.
- Written Communication** - It is ok to mail to my home address
- Fax Communication** - It is ok to fax to this telephone number: _____
- Email** -It is ok to email this address with detailed information: _____

You may leave a message with, discuss my treatment, appointments, financial obligations, or other scheduling that may occur or give other information as necessary with the following family, friends or personal representatives. I understand that The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC. will refuse to discuss my information with anyone not listed below, except in an emergency. I also understand this consent does not apply to medical providers.

Please Print:

Patient Signature

Date

Please Print Name:

Acknowledgement of Receipt of Notice of Privacy Practices:

I have received a copy of the Notice of Privacy Practices for The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC, detailing how information may be used and disclosed as permitted under federal and state law. I understand this is an acknowledgement of receipt only. I may refuse to sign this acknowledgement if I wish.

Patient Signature

Date

Signature of Patient Representative (Required if patient is a Minor or an Adult who is unable to sign this form)

Relationship: Self Mother Father Power Of Attorney Guardian Spouse

(For Internal Use Only)

If Patient or Patient's Representative Refuses to sign Acknowledgement of Receipt of Notice, please document the date and time the notice was presented to the patient and sign here:

Presented by: _____ Date: _____ Time: _____

Advance Directive/Living Will

Do you have an Advance Directive (Living Will, DNR-Do Not Resuscitate)? Yes No

For a copy of the Georgia Advanced Directives for Healthcare, please visit www.aging.dhr.georgia.gov and click on "Publications" on the left, or call DAS at (404)-657-5319

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	Subscriber's Social Security #:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Subscriber's Employer:	Work Phone: ()	
	<u>SECONDARY</u> Insurance Carrier:		Policy Number:		Group Number:	
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	Do you have an Employer Group Health Coverage Plan? <input type="checkbox"/> YES <input type="checkbox"/> NO					
	Is your Spouse still working? <input type="checkbox"/> YES <input type="checkbox"/> NO Retirement Date: _____					
Are you covered through your Spouse's Insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO						
<p>By Signing Below, I acknowledge that the information I have provided is correct to the best of my ability.</p> <p>Patient Signature: _____ Date: ____/____/____</p> <p>Guarantor Signature (if other than patient): _____ Date: ____/____/____</p>						

The Georgia Institute For Plastic Surgery and The Plastic Surgery Center Land, LLC

Payment Policy / Assignment of Benefits / General Disclosures

I hereby authorize and assign payment of my insurance benefits to be paid directly to The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC., any medical or surgical benefits that the professional corporation may be entitled to under my medical-surgical plan. I understand I am financially responsible for non-covered services and for any balance due for services in excess of the benefits provided by my policy. I authorize the release of any medical or other information necessary to process insurance claims on my behalf. I further permit a copy of this authorization to be used in place of the original. This authorization is to apply to all private insurance claims and Medicare benefits I may use.

Financial Liability: All services rendered by the physicians in this office are on a fee for service basis. Deductibles and co-insurance obligations associated with your chosen plan are your responsibility. These will be collected at the time of service for office visits. For cosmetic surgery or other scheduled procedures, these will be collected at least two weeks prior to the procedure/surgery. I understand that I will be responsible for any charges if any of the following apply:

- My health plan requires prior referral by a Primary Care Physician (PCP) before receiving services at The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC. and I have not obtained such a referral or I receive services in excess of the referral, and/or
- My health plan determines that the services I receive at The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC. are not medically necessary and/or not covered by my Insurance plan, and/or
- My health plan coverage has lapsed or expired at the time I receive services at The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC., and/or
- I have chosen not to use my health plan coverage, and/or
- They physician I see does not participate with my health care plan.
- If for any reason the account my account should become delinquent, I or my responsible party agrees to pay for all rebilling charges, collection costs, and reasonable legal fees.

Ancillary Services

- I understand I may need certain ancillary medical services while I am a patient at The Georgia Institute For Plastic Surgery / The Plastic Surgery Center Land, LLC; such as pathology specimen examination, cytology, imaging services, lab work, and cardiac tests. I understand that these services are not provided by any physician of this practice and that I may incur additional charges as a result of the ancillary services. I understand that these services will be billed to me directly, or may required payment from me at the time of service. In addition, I may receive in-patient or out-patient hospital care at an area hospital. If so, I will receive a hospital bill for those services. Hospital bills are separate from our doctor services. I am responsible for providing the name of the preferred hospital, laboratory or any other preferred facility/physician in network with my insurance plan.

Release and Authorization of Information:

- I authorize release of information to my primary care physician.
- I authorize release of information to my referring physician.
- I authorize release of information to my employer if this is a work related condition.
- I understand 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. I understand these photographs will be used solely for documentation purposes and will be kept confidential.
- I have read the Patient Financial Policy and I agree to abide by all terms. A copy of this policy is available on our website, in our lobby, or you may request a hard copy from the front desk.
- **Medicare Signature On File (*Medicare Patients Only*):** I request that payment of authorized Medicare benefits be made either to me or on my behalf to all providers who treat me for any services furnished to me by these providers. I authorize the holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Patient Signature

Date:

MEDICAL AND SURGICAL HISTORY

THE GEORGIA INSTITUTE FOR PLASTIC SURGERY
THE PLASTIC SURGERY CENTER LAND, LLC



Please Fill Out COMPLETELY - Do Not Leave Anything Blank

Today's Date: _____ Patient Name: _____ Date of Birth: _____

Sex: Male / Female Height: _____ Weight: _____ Age: _____

Occupation: _____ Referred by: _____

All of Your Medical Doctors: _____

Chief Complaint: _____

SIGNIFICANT MEDICAL HISTORY:

Medical Allergies/Sensitivities: _____ Pregnant? N Y

List ALL Medications {including Aspirin, Diet Pills, Herbal Supplements, Prescriptions, Over-The Counter Meds}: _____

Are you a smoker? NO YES How many packs per day? _____ For how many years? _____

Have you ever used {circle}: LSD/speed/cocaine/marijuana None How much alcohol do you drink? _____

PAST MEDICAL HISTORY { Please check all that apply. }			
Cardiovascular	Pulmonary	Medical	Other
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bleeding Tendencies
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Heart Burn/Reflux	<input type="checkbox"/> Blood clots in legs/lungs
<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Depression	<input type="checkbox"/> AIDS/HIV positive
<input type="checkbox"/> Chest Pain {angina}	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Steroid treatment	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Seizures	<input type="checkbox"/> Dry Eyes
<input type="checkbox"/> Abnormal EKG		<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> NONE OF THE ABOVE	<input type="checkbox"/> NONE OF THE ABOVE	<input type="checkbox"/> NONE OF THE ABOVE	<input type="checkbox"/> NONE OF THE ABOVE

FAMILY HISTORY

Have you or anyone in your family ever had problems with anesthesia? YES / NO

If yes, who and what happened? _____

Any Family History of: Heart Disease Lung Disease Malignant Hyperthermia Other

Describe: _____

REVIEW OF SYSTEMS: Do you have any? (circle): fever chills nausea vomiting diarrhea NONE

PAST SURGICAL HISTORY: List all Operations you have had, including plastic surgery.	
OPERATION	DATE
<input type="checkbox"/> I have NOT had any Operations.	

Do you have any other health issues that we may need to be aware of? NONE / YES Explain: _____

PATIENTS, PLEASE STOP HERE. THANK YOU!

Physician Signature: _____ / _____
Date Time

HISTORY AND PHYSICAL
THE GEORGIA INSTITUTE FOR PLASTIC SURGERY
THE PLASTIC SURGERY CENTER LAND, LLC



Chief Complaint: _____

PHYSICAL EXAM	
HEENT:	<input type="checkbox"/> PERRLA <input type="checkbox"/> EOMs intact
HEART:	<input type="checkbox"/> RRR without murmur
PULM:	<input type="checkbox"/> Lungs clear
ABD:	<input type="checkbox"/> Soft, non-distended
EXTREM:	
BREAST:	<input type="checkbox"/> No palpable masses <input type="checkbox"/> Deferred
OTHER:	

IMPRESSION: _____

PLAN: _____

PREVIOUS PAGE HISTORY REVIEWED AND UPDATED. The patient is cleared for surgery in an ambulatory surgical setting.

PHYSICIAN SIGNATURE: _____ Date/Time: ____/____/____

OTHER COMMENTS: _____

The History and Physical Exam remain valid from the above date.

If not, list changes: _____

PHYSICIAN SIGNATURE: _____ Date/Time: ____/____/____

SKIN LESION, SKIN CANCER, SOFT-TISSUE TUMOR REMOVAL DISCUSSION:

Risks/Benefits/Alternatives discussed with patient: infection, bleeding, delayed healing in smokers, widened or hypertrophic scars, keloid scarring, additional surgery for positive margin or recurrence, scars at recipient site, scars and grafts that take over 2 years to mature, recurrence, option of no treatment.