Advanced Plastic Surgery Center

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Date: _____

Patient Name: _____ Home Phone#: _____
first middle initial last

Address: _____ City: _____ State: _____ Zip: _____

SS#: _____ Birthdate: _____ Age: _____ Married/Single/Widowed/Divorced Sex: ____

E-mail Address: _____ Cell Phone: _____ Work Phone: _____

Patient/Parent Employer: _____ Occupation: _____

Employer's Address: _____ Work Phone: _____

Spouse's Name: _____ Employer: _____ Occupation: _____

Employer's Address: _____ Work Phone: _____

MEDICAL INFORMATION

Who referred you (i.e. doctor, friend, ER): _____ Phone #: _____

Family Physician Name & Address: _____ Phone #: _____

Reason for Consultation: _____

List All Drug Allergies: _____ List Any Past Surgeries: _____

List Medications Taken Daily (including aspirin): _____

Any Personal History of:

Heart Disease	❑Yes	❑No	**Bleeding Disorder**	❑Yes	❑No	**Psychiatric Care**	❑Yes	❑No
Diabetes	❑Yes	❑No	**Hepatitis**	❑Yes	❑No	**Depression**	❑Yes	❑No
High Blood Pressure	❑Yes	❑No	**HIV/AIDS**	❑Yes	❑No	**Chemical Dependency**	❑Yes	❑No
Asthma	❑Yes	❑No	**Smoking**	❑Yes	❑No	**Eating Disorder**	❑Yes	❑No
Liver Disease	❑Yes	❑No	**Poor Circulation**	❑Yes	❑No	**Anxiety/Panic Disorder**	❑Yes	❑No
Kidney Disease	❑Yes	❑No	**Anemia**	❑Yes	❑No	**Obsessive Compulsive Disorder**	❑Yes	❑No
						Alcohol Abuse	❑Yes	❑No

Height _____ **Weight** _____ **Other (Please List):** _____

INSURANCE/BILLING INFORMATION

Were your injuries from an: **auto accident** yes / no **work accident** yes / no Date of injury: _____

If this is an auto accident or workers' compensation, please refer to the back of this information sheet.

Primary Insurance Company Name: _____ Phone #: _____

Claim Address: _____

Subscriber's Name: _____ SS#: _____ Birthdate: _____

Identification Number: _____ Group / Account #: _____

Secondary Insurance Company Name: _____ Phone #: _____

Claim Address: _____

Subscriber's Name: _____ SS#: _____ Birthdate: _____

Identification Number: _____ Group / Account #: _____

Please complete if applicable.

WORKERS' COMPENSATION

Name of Employer: _____ Supervisor/Manager Name: _____

Complete Mailing Address: _____ Phone #: _____

Summary of How Injury Occurred: _____

Date of Accident: _____ Date Reported to Employer: _____

Attorney's Name: _____ Phone #: _____

AUTO ACCIDENT

Name of Auto Insurance Company: _____ Phone #: _____

Complete Claims Address: _____

Claim Number (not policy number): _____ Adjuster's Name: _____

Date of Accident: _____ Attorney's Name: _____ Phone #: _____

OFFICE POLICIES FOR Advanced Plastic Surgery Center

- With my consent, Dr. Chang, Dr. Kim, Dr. Thornton, Dr. Zabel and their office staff may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operation (TPO). I also authorize them to call my home or designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. With this consent, Dr. Chang, Dr. Kim, Dr. Thornton and Dr. Zabel may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements. By signing this form, I am consenting to Dr. Chang, Dr. Kim, Dr. Thornton and Dr. Zabel's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. Chang, Dr. Kim, Dr. Thornton and Dr. Zabel may decline to provide treatment to me. I hereby authorize Dr. Chang, Dr. Kim, Dr. Thornton and Dr. Zabel to treat me, or my child by medical means they deem necessary or advisable. I further authorize payment of my medical benefits to Dr. Chang, Dr. Kim, Dr. Thornton and Dr. Zabel. I understand the above guidelines, have had the opportunity to ask questions and will be given a copy of the privacy notice if I request it.

- In order to treat you as a patient and to submit your claims to the proper insurance company, this information sheet must be **completely** filled out.

- This office must be supplied with all necessary referrals and completed claim forms at the time of your visit. It is the responsibility of the patient to make sure your visits are authorized by your insurance company. If your insurance company requires referrals/ authorizations from your primary care physician, this office must receive the authorization/referral within 10 days. After 10 days, you will be responsible for all bills.

- Payment for all office visits must be made at the time of service. If you are involved in a legal matter, payments must still be received on a monthly basis to keep your account in good credit.

- This office allows 60 days after insurance has been filed for the insurance company to make a payment or to receive a response. After this time, the patient is responsible for making payments on the balance and also actively pursuing the insurance company to find out the delay in payment.

- Photos taken are the property of the Advanced Plastic Surgery Center. Photos may be released to your insurance company to determine medical necessity.

- Work injuries will be filed to the workers' compensation carrier that has been provided to you. However, any balance not paid by your workers' compensation carrier will be billed to you directly and will be your responsibility.

Patient/Parent Signature: _____