Patient Information Form

We appreciate you taking the time to fill out these forms. Please print clearly and answer completely.

Full Legal Name _____ Nickname _____

□ Male □ Female

Home Phone_____

Address _____

Cell Phone _____

City _____ State _____ Zip _____

Work Phone _____

Date of Birth _____

SSN _____

Marital Status □ Single □ Married □ Divorced □ Widowed

Email _____

Employer _____

Race □ Asian □ Black/African American □ White/Caucasian □ Other

Ethnicity □ Hispanic □ NOT Hispanic

Primary Language _____

Which Doctor referred you to our office? (*First & Last Name*) _____

Who is your Primary Care Doctor? (*First & Last Name*) _____

What is your preferred pharmacy? (*Name & City*)_____

Parent or Responsible Party Information

This portion needs to be filled out **ONLY** if the patient is age 17 years and younger. The responsible party is who fills out these forms.

Parent/Guardian Name _____Date Of Birth _____

Address _____ □ Male □ Female

City _____ State _____ Zip _____

Primary Phone # _____

Employer _____ Employment Status □ Part Time □ Full Time

Patient's relationship to Responsible Party _____

Health Insurance Information

Despite our office scanning your cards, this section *still* needs to be filled out completely. If we do not have all information we need, we cannot bill your insurance correctly. Please answer all of the following…

PRIMARY INSURANCE

Company _____

Address _____

Subscriber Name _____

Subscriber D.O.B _____

Subscriber I.D _____

Group Name _____

Group # _____

Relationship to Patient _____

SECONDARY INSURANCE

Company _____

Address _____

Subscriber Name _____

Subscriber D.O.B _____

Subscriber I.D. _____

Group Name _____

Group # _____

Relationship to Patient_____

Patient Name _____Date Of Birth_____

Release of Medical Information

By signing below, (see ***X*** below) I authorize the doctors and staff at Peak Plastic Surgery and its affiliates to disclose my protected health information, including but not limited to office notes, diagnostics tests and lab results to the below-named persons (e.g. spouse or parent.) This authorization shall be effective until I revoke in writing.

Individual # 1 _____ Individual #2 _____

Relationship to Patient _____ Relationship to Patient _____

Financial Policy & Notice of Privacy Practices & Photos Consent

I am responsible, regardless of insurance coverage, for payment of all rendered services. I am responsible for copayments, deductible amounts, co-insurance, non-covered services, or services deemed as "non-medically necessary" by my insurance carrier. **I understand co-payments are due at the time of service**. I am responsible for providing correct/updated insurance information so this office can bill my insurance. I understand that interest will accrue on all amounts 30 days and older at the rate of 18% annually until paid in full. If any amounts are referred to a third party collection agency, I am responsible for a collection fee up to 40% of the principal amounts owing as allowed by Utah Code annotated, sec. 12-1-11 in addition to any other amounts, such as interest, attorney fees or court costs. **I understand that some medical services performed in the office (e.g., injections, sutures, tissue removal, and other procedures) are billed separately from the office visit.**

By signing below, I acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practices. I give permission for staff at Peak Plastic Surgery to take and use, as deemed proper, photographs pertinent to my medical care. Furthermore, I have read the Financial Policy above and agree to abide by its guidelines.

X Patient/Resp. Party Signature_____ Date _____

Emergency Contact *(not living with you)*

Name _____Relationship _____ Phone_____

Address _____ City _____ State _____ Zip_____

MEDICAL HISTORY FORM

Name:_____ Age:_____ Date of Birth_____/_____/_____

Date symptoms started:_____ Primary reason for visit:_____

LIST ALL DIAGNOSED MEDICAL CONDITIONS

□ Heart problems □ Diabetes
□ Stroke □ Cancer *(list type)*
□ Asthma or lung problem

_____

_____

_____

_____

LIST ALL PREVIOUS SURGERIES

_____

_____

_____

_____

_____

_____

LIST ALLERGIES TO MEDICATIONS: □ No Known Allergies

_____

_____

SOCIAL HISTORY *(check all that apply)*

□ Alcohol use: _____ drinks per week □ No Alcohol use

□ At risk for HIV infection
(unprotected sex, IV drug use, history of blood transfusions)

□ History of drug use

Smoking Status: □ Current If current: _____ packs per day
□ Former (when quit: _____)
□ Never smoked

Second hand smoke exposure:
□ Environmental □ Occupational □ Perinatal/before birth

□ Tobacco use (other/chew): _____

PEDIATRIC PATIENTS ONLY *(check all that apply)*

□ Premature birth (<38 weeks) or low birth weight
□ Infection or other problem during pregnancy of birth
□ Immunizations are up-to-date
□ Developmental delay (speech, walking, other)
□ Lives with someone who smokes
□ Attends day care

LIST CURRENT MEDICATIONS & SUPPLEMENTS:
(use back of this form for more space)

Name	**Dose**	**Frequency**	**Route** (oral, injection, etc.)

MEDICAL HISTORY FORM...continued

Name:_____ Date of Birth_____/_____/_____

FAMILY HISTORY *(check if blood relatives have the following)*

DISEASE	RELATIONSHIP TO YOU
☐ BRCA Positive	_____
☐ Breast Cancer	_____
☐ Diabetes	_____
☐ Heart Disease	_____
☐ Hemophilia	_____
☐ High Blood Pressure	_____
☐ Obesity	_____
☐ Cancer	_____

☐ None of the above

REVIEW OF SYSTEMS

CHECK ☐ ALL THAT APPLY (Problems you have had within the past 3 months)

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Palpitation or heart racing
- ☐ Swelling in legs or feet

EARS
- ☐ Ear infections
- ☐ Hearing problems
- ☐ Vertigo

ENDOCRINE
- ☐ Diabetes
- ☐ Heat or cold intolerance
- ☐ Thyroid problems

EYES
- ☐ Blurry vision
- ☐ Double vision

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Recent weight change

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea or vomiting

HEMATOLOGIC/LYMPH
- ☐ Anemia
- ☐ Easy bruising or bleeding

INTEGUMENTARY (SKIN)
- ☐ Changes in hair or nails
- ☐ New stretch marks
- ☐ Rashes

MOUTH and THROAT
- ☐ Dry mouth
- ☐ Frequent sore throats

MUSCULOSKELETAL
- ☐ Back pain
- ☐ Muscle cramps
- ☐ Swelling or pain in joints

NEUROLOGIC
- ☐ Frequent headaches
- ☐ Loss of consciousness
- ☐ Numbness or tingling

NOSE and SINUS
- ☐ Frequent colds
- ☐ Nasal stuffiness

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression

RESPIRATORY
- ☐ Frequent cough
- ☐ Shortness of breath
- ☐ Wheezing

☐ I have none of the above symptoms

I have reviewed the above and checked all symptoms which apply.

Patient/Representative Signature:_____ Today's Date:_____