STEINMETZ PLASTIC SURGERY

NEW PATIENT

PATIENT INFORMATION:

Patient's Name: _____ D.O.B: _____

Age: _____ Social Security: _____Height:_____ Weight: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Email Address: _____

Occupation: _____ Employer: _____

Referring Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

EMERGENCY CONTACT INFORMATION:

Spouse: _____ Phone: _____

Nearest Relative: _____ Phone: _____

MEDICAL INSURANCE INFORMATION:

Primary Insurance Company: _____

Name as it appears on card: _____

Contract Number: _____ Group Number: _____ Copay: _____

Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

Secondary Insurance Company: _____

Name as it appears on card: _____

Contract Number: _____ Group Number: _____ Copay: _____

Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

RESPONSIBLE PARTY [IF MINOR OR OTHER THAN PATIENT]:

Name: _____ Phone: _____

The patient and responsible party listed above hereby agree to any and all amounts and charges submitted by Dr. Steinmetz for services rendered during the course of treatments for the patient including hospitalization, unless Dr. Steinmetz is otherwise obligated to accept payment solely from a third party. The patient and the responsible party hereby acknowledge, understand and agree that they are financially responsible to Dr. Steinmetz, even though there may be insurance or other third party coverage, and agree that failure to make payment when requested is basis for legal action, and agree to pay any and all costs of collection, including a reasonable attorney fee. The patient and responsible party hereby acknowledge their understanding that payment is due in full upon receipt of invoice statement. The patient and responsible party recognize and agree that they, and not any insurance company, are solely responsible for the entire bill.

I hereby authorize the release of any medical information necessary to process all claims. I also authorize and request payment of benefits be made directly to Stephen R. Steinmetz, M.D.

Signature: _____ **Date:** _____

MEDICAL HISTORY:

Patients name: _____ Age: _____

Referred by: _____

Reason for visit: _____

Is your visit today a result of injury or accident? ☐ Yes ☐ No

If yes, please list the date of accident: _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING [PRESCRIPTION, OVER THE COUNTER, ETC]:	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Are you allergic to any medications?	☐ Yes	☐ No
If yes, please list:		

PLEASE LIST ALL PREVIOUS SURGERIES:	
1.	Date:
2.	Date:
3.	Date:
4.	Date:
5.	Date:

PLEASE LIST ANY MEDICAL PROBLEMS YOU ARE CURRENTLY BEING TREATED FOR:

Patient's Name: _____ Age: _____

Height: _____ Weight: _____ Number of Children: _____

MEDICAL HISTORY:

Please check all that apply:

LUNGS:
- ☐ Born with any lung disease
- ☐ Cough or Cold (presently)
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Smoke _____ pack of cigarettes per day for the past _____ years.

HEART:
- ☐ Born with any heart disease
- ☐ Heart Murmur
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Skipped heart beats
- ☐ Chest pain
- ☐ Hardening of the arteries
- ☐ Heart failure
- ☐ Heart attack
- ☐ Rheumatic fever

BLOOD:
- ☐ Bruise or bleed easily
- ☐ Abnormal bleeding
- ☐ Sickle cell trait/disease
- ☐ Other blood disease
- ☐ Prolonged bleeding

LIVER:
- ☐ Drink alcoholic beverages
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Other liver disease

KIDNEY:
- ☐ Born with kidney disease
- ☐ Kidney infections/disease
- ☐ Kidney stones

OTHER:
- ☐ Pain in breast
- ☐ Drainage from nipples
- ☐ Fibrocystic disease
- ☐ Biopsies [if yes, how many? _____]
- ☐ Family history of breast cancer
- ☐ AIDS
- ☐ Exposure to AIDS
- ☐ Hepatitis
- ☐ Exposure to hepatitis

NERVOUS SYSTEM:
- ☐ Born with abnormality
- ☐ Brain disease
- ☐ Spinal cord disease
- ☐ Nerve disease
- ☐ Epilepsy
- ☐ Stroke

ENDOCRINE:
- ☐ Diabetes
- ☐ Thyroid Disorder

EYE:
- ☐ Glaucoma
- ☐ Contact lenses

STOMACH, BOWEL AND GALLBLADDER:
- ☐ Any disease of

AIRWAY:
- ☐ Problems opening mouth
- ☐ Problems turning head any direction
- ☐

REPRODUCTIVE:
- ☐ Pregnant
- ☐ Planning pregnancy
- ☐ Have you breast fed in the last 3 months

MUSCULOSKELETAL [injury or damage to any]:
- ☐ Joints
- ☐ Tendons
- ☐ Nerves

EYE, EAR, NOSE & THROAT:
- ☐ Hard lumps on tongue, lips or mouth
- ☐ Trouble swallowing
- ☐ Trouble with nose, mouth or throat
- ☐ Eye disease
- ☐ Dry eyes
- ☐ Ear disease
- ☐ Impaired hearing

Please list any other medical information that may be important to Dr. Steinmetz:

AUTHORIZATION FOR RELEASE OF INFORMATION

☐ I **DO NOT** wish to have test results or other information released to any person other than myself.

☐ I do wish to have test results or other information released to the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

It is the responsibility of the patient to notify this office of any changes in the above information. If changes do occur, the patient must file another Authorization for Release of Information with the office of Stephen R. Steinmetz, M.D.

Please understand that it may be necessary for us to disclose some or all of the information contained in your medical records to other physicians, nurses and/or healthcare providers [collectively referred to as "providers"]. Occasionally, other providers assist us in assessing a patient's condition, screening for potential problems or providing consultation under certain circumstances. You can be assured that those professional healthcare providers will maintain your patient confidentiality.

Also, due to the increased awareness of quality care and outcome measurements, it may be necessary to disclose information regarding your care to healthcare agencies [both private and governmental], your insurance company and/or your self-insured employers. Regarding information going to your employer, other than information to verify insurance coverage, the data released will only consist of statistical information.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I understand that as part of my healthcare, Dr. Steinmetz originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and any future care or treatment. Depending on my condition, photos may be included. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A means of information applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been given the opportunity the review the Notice of Health Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Dr. Steinmetz reserves the right to change his notice and practices but will mail me a copy of any revised notice to the address I have provided prior to implementing the change. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that Dr. Steinmetz is not required to agree to the restrictions requested. I also understand that I may revoke this consent in writing, except to the extent that Dr. Steinmetz has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulation. I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and accept the terms of this consent:

_____ _____
Signature Date

_____ _____
Witness Date

FOR OFFICE USE ONLY

- ☐ Consent received by _____ Date: _____
- ☐ Consent refused by patient and treatment refused as permitted.
- ☐ Consent added to the patient's medical record.