BEND PLASTIC SURGERY

ADAM P. ANGELES, M.D.
Physician and Surgeon
Cosmetic, Plastic & Reconstructive Surgery

Patient Name:_____ Date: _____ Sex: M/F

Date of Birth:_____ Age:_____ Home Phone: _____

Social Security Number _____/_____/_____ Cell Phone: _____

Address:_____ City: _____ Zip: _____

Primary Care Physician: _____ Referring Physician: _____

Reason for visit: _____

Email address: _____

Emergency Contact: _____Relationship: _____ Phone: _____

Can we disclose medical information to your emergency contact if need be? Yes / No _____ Initial

MEDICAL HISTORY: Please check any items that you and your family members currently have a diagnosis for or have had in the past (**PLEASE WRITE IN WHICH FAMILY MEMBER HAS THAT DIAGNOSIS** ie: paternal grandpa):

Self	Family: (List who)		Self	Family: (List who)		Self	Family: (List who)	
		Abnormal Bleeding/clots			Fibromyalgia			Liver Disease
		Alzheimer's			Headaches			Lung Disease
		Anemia			Heart Attack			Malignant Hyperthermia
		Anxiety			Heart Disease			Neuropathy
		Arthritis			Heart Murmur			Osteoporosis
		Asthma			Hemochromatosis			Parkinson's
		Autoimmune Disease			Hepatitis			Previous Radiation Therapy
		Back Pain			High Blood Pressure			Psoriasis
		Benign Breast Disease			High Cholesterol			Schizophrenia
		Blood clot in lung or legs			HIV			Seizures
		Blood Transfusions			Hodgkin's			Skin Disease
		Cancer of:			Hypertrophic Scarring			Stomach Ulcer
		Cold Sores			Hypoglycemia			Stroke
		Connective tissue disease			Irregular Heart			Substance Abuse
		Depression			Irritable Bowel Syndrome			Tuberculosis
		Diabetes			Kidney Stones/Disease			Thyroid Disorder
		Emphysema			Leukemia			Urinary Incontinence

Entered in Nextech by _____

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Medication Sheet

Patients Name:____

What pharmacy do you use?____________________________________

Date	List current prescription medications	Strength	How often do you take?	Initials

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SURGICAL HISTORY: Please list all surgeries you have had and the approximate dates:

Date	Surgery	comments

ANESTHESIA COMPLICATIONS:

Have you had any complications with anesthesia or PONV (Post-Operative Nausea and Vomiting)?_____

ALLERGIES:

To Medications:_____

Reaction: _____

To Food:_____

Reaction:_____

To other substances such as latex, adhesive tape, metal, iodine, etc.:_____

Reaction:_____

SOCIAL HISTORY: Please answer the following as honestly as possible:

Do you drink alcohol? Yes_____no_____ If yes, How often?_____Drinks a day. ___ Just Socially.

Have you ever used recreational drugs(i.e. Marijuana, Methamphetamines, Cocaine, or Heroine)? Yes_____No_____

If yes, what and for how long?_____

Have you ever had/have a sexually transmitted disease? Yes_____No_____ What?_____

Do you smoke tobacco? Yes_____no_____If yes, how much?_____

Have you ever smoked tobacco? Yes_____no_____When did you quit smoking?_____

Do you exercise regularly? Yes____no_____If yes, how often?_____

Have you traveled outside the United States in the last year? Yes_____ No____ If yes, where and when?_____

What is your occupation?_____Place of Employment?_____

Marital Status?_____Number of Children? _____

Pregnant or Nursing? Yes ___ No ___

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REVIEW OF SYSTEMS: Please check all the symptoms that apply now or in the past.

Constitutional
- ☐ loss of appetite
- ☐ fever
- ☐ weakness
- ☐ weight gain
- ☐ weight loss
- ☐ night sweats

Dermatology
- ☐ rash
- ☐ change in color of moles
- ☐ lumps
- ☐ dry or sensitive skin
- ☐ hives

Ophthalmology
- ☐ diminished vision
- ☐ eye irritation
- ☐ drainage from eyes
- ☐ blurring of vision
- ☐ seasonal eye surgery
- ☐ dander related eye surgery
- ☐ loss of vision

Allergy
- ☐ runny nose
- ☐ scratchy throat
- ☐ itchy eyes
- ☐ ear fullness
- ☐ sinus congestion
- ☐ stuffy nose

Gastroenterology
- ☐ nausea
- ☐ heartburn
- ☐ stool incontinence
- ☐ jaundice
- ☐ vomiting
- ☐ bloating/belching
- ☐ difficulty swallowing
- ☐ abdominal pain
- ☐ diarrhea
- ☐ constipation
- ☐ change in bowel habits
- ☐ blood in stool

Musculoskeletal
- ☐ joint swelling
- ☐ joint pain
- ☐ leg cramps
- ☐ joint stiffness
- ☐ muscle pain

Hematology/ Lympa
- ☐ swollen glands
- ☐ fatigue
- ☐ loss of appetite
- ☐ varicose veins
- ☐ easy bruising

Psychology
- ☐ high stress level
- ☐ depression
- ☐ sleep disturbances
- ☐ suicidal ideation
- ☐ eating disorder
- ☐ mental or physical abuse
- ☐ schizophrenia
- ☐ anxiety disorder

Cardiology
- ☐ chest pain
- ☐ palpitations
- ☐ leg swelling
- ☐ shortness of breath
- ☐ difficulty breathing at night

Ear nose and throat
- ☐ cold
- ☐ cough
- ☐ coughing blood
- ☐ nose bleed
- ☐ hearing loss
- ☐ change in voice
- ☐ sore throat
- ☐ ringing in ears
- ☐ snoring

Respiratory
- ☐ shortness of breath
- ☐ chest pain
- ☐ cough wheezing

Endocrinology
- ☐ fatigue
- ☐ excessive sweating
- ☐ excessive thirst
- ☐ excessive urination
- ☐ weight loss
- ☐ cold intolerance
- ☐ heat intolerance

Neurology
- ☐ headache
- ☐ tingling numbness
- ☐ seizures
- ☐ insomnia
- ☐ memory loss
- ☐ dizziness
- ☐ gait abnormality

Urology
- ☐ difficulty urinating
- ☐ blood in urine
- ☐ urinary urgency
- ☐ frequent urination
- ☐ urinary incontinence
- ☐ voiding dysfunction
- ☐ vulvodynia
- ☐ dyspareunia
- ☐ recurrent urinary tract infection
- ☐ nocturia

Female Reproductive
- ☐ heavy periods
- ☐ dyspareunia
- ☐ sexually active
- ☐ premenstrual syndrome
- ☐ dysmenorrhea
- ☐ infertility
- ☐ frequent yeast infections
- ☐ vaginal itching
- ☐ intermenstrual bleeding
- ☐ post coital bleeding
- ☐ postmenopausal bleeding
- ☐ pelvic pain
- ☐ irregular periods
- ☐ abnormal vaginal discharge
- ☐ hot flashes
- ☐ last mammogram_____
- ☐ last pap smear_____

Male Reproductive
- ☐ difficulty with erection
- ☐ difficulty with ejaculation
- ☐ diminished sexual drive

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CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize Adam P. Angeles, M.D. to use and disclose the health and medical information of :
_____ for the purpose of Treatment, Payment and Health Care Operations.*
(name of patient)

*Treatment (includes activities performed by a physician, nurse, office staff and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultation between other health care providers. This consent includes treatment provided by any physicians who cover my practice by telephone as the on-call physician).

*Payment (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

*Health Care Operations (includes the necessary administrative and business functions of our office).

You may review Bend Plastic Surgery's "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in the CONSENT prior to signing this CONSENT.

Please verify that you have received a copy of our Notice by placing your initials here: _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree with your request. If we do agree, we are required to comply with your request* unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that Bend Plastic Surgery Practice has already used or disclosed the information in reliance on this CONSENT.

_____ _____ or
Date (Signature of patient)

_____ _____
Date (Signature of person authorized by law)

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PHOTOGRAPHIC CONSENT FORM

For Insurance Purposes

In certain cases the insurance company will request photos and chart notes to process a claim. Please complete the below consent.

For Cosmetic Purposes

Photos are required for before and after as well as intra-operatively. These will only be used as part of your care and will be kept as a part of your chart.

Consent

I hereby grant permission for Bend Plastic Surgery to take my picture(s). I hereby grant the use of any of my medical records including illustrations, photographs or other imaging records created in my case.

_____ _____
Date (Signature of patient)

_____ _____
Date (Signature of witness)

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Financial Policy

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines.

Payment Options:
We accept Visa, MasterCard, personal checks and cash for insurance co pays. Please be aware that we will add a $35.00 charge to your account for returned checks. **CareCredit and Prosper** healthcare lending plans are available. We reserve the right to send all accounts with balances over 60 days old to an outside collection agency or small claims court if necessary. All accounts sent to collections will be charged a $50.00 processing fee and additional fees associated with the collection of your balance. You will be responsible for all reasonable collections and attorney costs incurred.

Social Security Information
In order to submit claims to insurance companies, along with other necessary billing related issues we require a social security number of the responsible party of this account.

Cancellations and No Show
Cancellations' within 24 hours of your scheduled appointment will result in a $50.00 cancellation fee. Failure to show for your appointment will result in a "no show" fee of $50.00. A $500.00 nonrefundable deposit is required for any surgical procedure.

Insurance
We offer benefit verification as a courtesy, however, it is your responsibility to verify insurance coverage and benefits prior to your appointment or procedure. As a patient, you will be responsible for any co pays, deductibles, additional testing, and services not covered by your insurance. If you do not have your insurance card, or we do not participate with your insurance plan, you can either reschedule your appointment or pay for your visit in full at the time services are rendered. Any balance left after your insurance has paid must be remitted within 30 days a 1.5% monthly finance charge (18% annually) is assessed to all balances over 30 days past due.

Private Party/Uninsured Patients
If you plan to pay privately for your services, please be advised that it is the policy of Bend Plastic & Reconstructive Surgery, PC practice to collect payment in full at the time of service. If you are unable to make payment in full at the time of service, your appointment will be rescheduled to a more convenient time.

Motor Vehicle Accidents (MVA)/Third Party Liability
We will require all claim details (claim#, contact info, billing address) at the time of your appointment; otherwise we will require payment in full for services rendered for each patient being treated for a MVA/other accident-related injury. We will file claim(s) with the motor vehicle or third party insurance company that you designate, provided we receive all necessary information with which to bill. If the claims are denied, or a protracted lawsuit is involved, the patient is responsible to pay the account balance in full. We will bill your private health care insurance if applicable for balance left after your personal injury protection (PIP) exhausted.

Form Fees
Forms and letters requested by our patients will be billed a fee as listed below. This list is not meant to be all inclusive but is merely representative of the items that may incur a charge. This fee covers our administrative expenses related to physician/staff time, photocopying, mailing, etc. Forms such as disability forms, workers comp, letters of medical necessity, family medical leave act forms, and MVA forms all incur a **$25.00 FEE.**

Acknowledgment
I have read and understand the Bend Plastic Surgery financial policy. I understand and agree that regardless of my insurance status, **I am ultimately responsible for the balance on my account for any services rendered, including any attorney fees and costs in arbitration, at trial and on appeal**. I certify that the information provided by me on the patient registration form is true and correct to the best of my knowledge.

_____ _____
Patient Name Responsible Party Signature (Print and sign)

_____ - _____ - _____ _____
Social Security Number Date