

Partners in Plastic Surgery of West Michigan

Today's Date:

Appt. Date:

Appt. Time:

Patient ID:

PATIENT GENERAL INFORMATION

FULL LEGAL NAME:		BIRTH DATE:		Age:	
STREET ADDRESS:		SEX:			
CITY, STATE, ZIP:		CELL #:			
HOME PHONE:		WORK #:			
SOCIAL SECURITY #:		E-MAIL:			
EMPLOYER:		POSITION:			
MARITAL STATUS	Married Single Widowed Divorced				

YOUR PRIMARY CARE PHYSICIAN AND PHONE #		NAME OF PHYSICIAN WHO REFERRED YOU TO US TODAY:	
WHAT IS THE REASON FOR YOUR VISIT TODAY			

SPOUSE GENERAL INFORMATION

FULL LEGAL NAME:		BIRTH DATE:		Age:	
STREET ADDRESS:		SEX:			
CITY, STATE, ZIP:		CELL #:			
HOME PHONE:		WORK #:			
SOCIAL SECURITY #:		E-MAIL:			
EMPLOYER:		POSITION:			

HOW DID YOU HEAR ABOUT DR. HAMMOND, DR. TIMEK OR DR. VAN PELT? PLEASE CIRCLE ALL THAT APPLY

ASPS	Doctor	Lectures	Magazines	Newspaper
Patient	TV	Radio	Walk-in	Website
Word of Mouth	Yellow Pages	Flyer	Movie Trailer	Sales Rep

Plastic Surgery Specialists of West Michigan

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Insurance Carrier Name _____	Insurance Carrier Name _____
Insurance Carrier Birthdate _____	Insurance Carrier Birthdate _____
Address _____ _____	Address _____ _____
Policy/ID# _____	Policy/ID# _____
Group# _____	Group# _____
Employer _____	Employer _____

**WHEN REGISTERING, PLEASE PRESENT YOUR INSURANCE CARD(S)
COPAYMENT IS EXPECTED AT THE TIME OF SERVICE**

INSURANCE INFORMATION

I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. SHOULD MY ACCOUNT BECOME DELINQUENT, I AGREE TO PAY INTEREST ON THE OUTSTANDING BALANCE OWED AT THE MAXIMUM AMOUNT PERMITTED BY LAW. IF PLASTIC SURGERY SPECIALISTS OF WEST MICHIGAN UNDERTAKES COLLECTION EFFORTS TO RECOVER ANY PAST DUE AMOUNT, I AGREE TO PAY ALL REASONABLE COSTS INCURRED, INCLUDING ATTORNEY'S FEES.

MEDICAL AUTHORIZATION

I _____ hereby authorize the release of any and all medical records, x-rays, or other information pertaining to my physical or mental condition to the office of Plastic Surgery Specialists of West Michigan located at 4070 Lake Drive Suite #202 of Grand Rapids, Michigan 49546.

Signature: _____

Date: _____

Signature of Parent/Legal Guardian: _____

Date: _____

Witness: _____

Date: _____

Plastic Surgery Specialists of West Michigan

Name:

Date:

EMERGENCY CONTACT PERSON

CONTACT PERSON'S NAME:		RELATIONSHIP TO PERSON:	
STREET ADDRESS:		CITY, STATE, ZIP:	
CONTACT'S HOME #:		CONTACT'S CELL # OR WORK #	

IF PATIENT IS A MINOR – PLEASE COMPLETE THIS SECTION

LEGAL GUARDIAN'S NAME:		LEGAL GUARDIAN'S DATE OF BIRTH:	
STREET ADDRESS (IF DIFFERENT FROM ABOVE):		LEGAL GUARDIAN'S WORK PHONE:	
CITY, STATE, ZIP:		LEGAL GUARDIAN'S HOME PHONE:	
LEGAL GUARDIAN'S SOCIAL SECURITY #:		LEGAL GUARDIAN'S CELL PHONE:	
LEGAL GUARDIAN'S EMPLOYER:		LEGAL GUARDIAN'S RELATION TO PATIENT:	
ALSO THE EMERGENCY CONTACT?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**ARE YOU INTERESTED IN RECEIVING OUR COMPLIMENTARY NEWSLETTER?
KEEP UPDATED ABOUT OUR OFFICE, DOCTORS, AND PRODUCT SPECIALS FROM OUR
LICENSED AESTHETICIAN** (WE WILL NOT GIVE YOUR NAME OR INFORMATION TO ANY OTHER ORGANIZATION. WE WILL SEND OUR NEWSLETTER WITH RENOUVEAU SPECIALS, AND PERSONALIZED INVITES TO INFORMATIONAL SEMINARS ON SERVICES AND PRODUCTS OFFERED IN OUR OFFICE)

Yes, please send me the newsletter.

No, I am not interested.

Plastic Surgery Specialists of West Michigan

Name: _____

Date: _____

PATIENT MEDICAL HISTORY

Height: _____

Weight: _____

Age _____

Reason for today's visit _____

REVIEW OF SYSTEMS - ANSWER YES OR NO TO THE FOLLOWING. IF YOUR ANSWER YES, PLEASE CIRCLE THE CONDITION AND EXPLAIN.

NO	YES		EXPLAIN (date, etc.)
		CONSTITUTIONAL (FEVER, WEIGHT LOSS, NIGHT SWEATS)	
		CARDIOVASCULAR (HEART ATTACK, STROKE, CHEST PAIN, VALVE DISEASE)	
		RESPIRATORY (EMPHYSEMA, ASTHMA, TUBERCULOSIS)	
		ENDOCRINE (DIABETES, THYROID)	
		MUSCULOSKELETAL (PREVIOUS FRACTURE, MUSCLE OR BONE DISEASE, ARTHRITIS)	
		INTEGUMENTARY (PSORIASIS, ECZEMA)	
		PSYCHIATRIC (DEPRESSION, ANXIETY)	
		HEMATOLOGIC (ANEMIA, BLEEDING TENDENCY, HISTORY OF BLOOD CLOTS IN YOUR LEGS OR LUNGS)	
		GENITAL/URINARY (INFECTION, KIDNEY STONES, PROSTATE)	
		GASTROINTESTINAL (ULCER, GASTRITIS, COLITIS)	
		EYES (GLAUCOMA, CATARACTS)	
		EARS/NOSE/MOUTH/THROAT	
		NEUROLOGICAL (SEIZURES, NUMBNESS, TREMORS)	
		OTHER PROBLEMS (HIGH CHOLESTEROL OR BLOOD PRESSURE, CANCER)	

PREVIOUS SURGERY

SURGERY DESCRIPTION	DATE (MONTH, YEAR)

_____ physicians signature

_____ date

Plastic Surgery Specialists of West Michigan

Name: _____

Date: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS?

YES

NO

IF SO, PLEASE LIST _____

REACTIONS, IF ANY _____

CURRENT MEDICATIONS

1.	2.
3.	4.
5.	6.

FAMILY HISTORY

HAVE ANY FAMILY MEMBER SUFFERED FROM ANY OF THE CONDITIONS LISTED BELOW?

NO	YES		RELATION TO YOU
		LUNG DISEASE/ASTHMA/EMPHYSEMA	
		HEART DISEASE/STROKE/HEART ATTACK	
		HIGH BLOOD PRESSURE	
		DIABETES	
		CANCER (WHAT TYPE)	
		RHEUMATOID ARTHRITIS/LUPUS/FIBROMYALGIA	
		OTHER	

SOCIAL HISTORY

MARITAL STATUS (Please circle): S M W D HOW MANY CHILDREN? _____ THEIR AGES _____

DO YOU SMOKE? _____ IF YES, HOW MANY YEARS? _____ HOW LONG SINCE YOU QUIT? _____

DO YOU DRINK ALCOHOL? _____ IF YES, HOW MANY DAYS PER WEEK? _____

WHAT TYPE OF WORK DO YOU DO? _____

ARE YOU A JEHOVAH'S WITNESS? YES NO DO YOU HAVE A PROBLEM RECEIVING BLOOD TRANSFUSIONS? YES NO

**GENERAL CONSENT FOR TREATMENT/EVAULATION AND
RELEASE OF INFORMATION**

Name: _____

Date: _____

- Consent for general treatment.** I authorize healthcare services be provided by the medical staff of Plastic Surgery Specialists of West Michigan. This includes, but is not limited to routine diagnostic procedures, surgery, routine medical nursing, and all forms of patient care.
- No representations or guarantees.** I am aware that the practice of medicine is not an exact science. I acknowledge that no oral or written representations or guarantees have been made to me as the result of any diagnosis, treatment or medical care that I may receive as a patient of the Plastic Surgery Specialists of West Michigan.

Plastic Surgery Specialists of West Michigan

DIRECTIONS TO OUR OFFICE

We are located on the South/East corner of East Paris and Lake Drive. We are the first drive on the right past the intersection and the large white address numbers are located at the top of our brick building located behind Michigan Commerce Bank. Our office is on the second floor.

Directions from the NORTH (Big Rapids)

- Take 131 SOUTH towards GRAND RAPIDS
- Take either 96 EAST (around town) or 196 EAST (through town) towards LANSING
- Take the CASCADE WEST exit (exit #40A).
- Turn LEFT at 2nd light onto EAST PARIS.
- Turn LEFT at 2nd light onto LAKE DRIVE.
- Take FIRST DRIVE on the RIGHT.
- We are in the building behind Michigan Commerce Bank.

Directions from the EAST (Lansing)

- Take 96 WEST towards GRAND RAPIDS.
- Take the CASCADE WEST exit (exit #40A).
- Turn LEFT at 2nd light onto EAST PARIS.
- Turn LEFT at 2nd light onto LAKE DRIVE.
- Take FIRST DRIVE on the RIGHT.
- We are in the building behind Michigan Commerce Bank.

Directions from the SOUTH (Kalamazoo)

- Take 131 NORTH to GRAND RAPIDS.
- Take 196 EAST (through town) towards LANSING
- Take the CASCADE WEST exit (exit #40A)
- Turn LEFT at 2nd light onto EAST PARIS.
- Turn LEFT at 2nd light onto LAKE DRIVE.
- Take FIRST DRIVE on the RIGHT.
- We are in the building behind Michigan Commerce Bank.

Directions from the WEST (the shore of Lake Michigan)

- Take 196 EAST
- Take M6 Paul Henry Freeway to 96 WEST towards Grand Rapids
- Take the CASCADE WEST exit (exit #40A)
- Turn LEFT at 2nd light onto EAST PARIS.
- Turn LEFT at 2nd light onto LAKE DRIVE.
- Take FIRST DRIVE on the RIGHT.
- We are in the building behind Michigan Commerce Bank.

Office Address: Plastic Surgery Specialists of West Michigan
4070 Lake Drive Suite 202
Grand Rapids, MI 49546
(616) 464-4420

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Grand Rapids, MI 49546
616.464.4420

