PARTNERS IN PLASTIC SURGERY OF WEST MICHIGAN

Dr. Dennis Hammond
and Dr. Andrea Van Pelt
4070 Lake Dr. Ste 202 Grand Rapids MI 49546
Ph. 616-464-4420 Fax 616-464-4354
email: office@pipsmd.com

Thank you for scheduling a consultation with our office. We are looking forward to meeting you and exceeding your expectations! Enclosed you will find patient information paperwork. We recommend that you fill these out at home and send them back in the enclosed stamped envelope. It is important for us to know your health history as thoroughly as possible, even if it doesn't seem relevant to what you're coming in to discuss. Keep in mind that when it comes to the human body, *everything* is connected! When discussing surgery, we'd rather have too much information than not enough.

What to expect the day of your consultation:

Plan to spend 1 to 2 hours at the office the day of your first appointment.

First, you will meet one of our amazing nurses: Ashley, Julie, Dawn, Sarah, or Jan. They will review your paperwork with you and ask some more questions in regards to your health and your procedure of interest. You will have the opportunity to register with our TouchMD system so that you can have access to some of the information about your consultation on your computer at home, if you choose.

Next, you will meet the surgeon. The doctor will discuss the procedure and give you some expert advice on how to best achieve the results for you. Photos will be taken, if appropriate, so that the doctor has a baseline to reference back to throughout your entire surgical experience. These photos are confidential and stored within our internal server as part of your medical record.

Again, a nurse will spend some time with you discussing the details of surgery and offering you as much education about the procedure as you'd like. This is a great time to make sure that you have all your questions answered and feel completely comfortable with all the information you've been given.

What to bring with you:

- Your completed paperwork.
- Your insurance information, including cards and ID.
- Questions! We recommend making a list at home so that in the excitement of your visit nothing gets forgotten.
- A friend or family member. The support is nice, an extra set of ears listening never hurts and we love to meet new people!
- A smile and sometimes… a little patience. We work VERY hard to stay on schedule but also strive to give each patient the time that they need, rather than hurrying them in and out, which can sometimes throw a wrinkle in expected times. Please understand that we will give you the same respect when it's your time.

If you need to reschedule your appointment, please let us know at least one day in advance. If you have any questions at all about your visit, our front office staff: Erin, Machelle, and Laura are available or feel free to talk to our Patient Coordinator, Jan. We want you to feel completely prepared and comfortable!

We look forward to seeing you.

Sincerely,

The Staff at Partners in Plastic Surgery
616-464-4420

PARTNERS IN PLASTIC SURGERY OF WEST MICHIGAN

WELCOME!

Patient Information: ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr. Date: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (Home): _____ (Work) _____ (Cell) _____

Email address: _____

SSN: _____ Birthdate: _____ Gender: ☐Male ☐Female

Patient's Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced

Would you like to be added to our email newsletter list for ongoing information and specials? ☐**Yes** ☐**No**

Patient's Employer: _____ Occupation: _____

Employer Address: _____ Phone #: _____

Ethnic Background : ☐American Indian/Alaska Native ☐Asian ☐Black/African American
☐Native Hawaiian/Pacific Islander ☐White ☐Other Race ☐Decline to answer

Preferred Language: _____

Reason for Visit: _____

Other Information

In Case of Emergency, who should we notify: _____

Emergency Contact's relationship to patient: _____ Phone #: _____

How did you hear about us?

☐Physician: _____ ☐Hospital: _____
☐Another Patient: _____ ☐Friend: _____
☐Website: _____ ☐Telephone Directory: _____
☐T.V. Ad ☐Seminar
☐Publication: _____
☐Other (i.e., Employee, Attorney, Referral Line):_____

Patient's Signature: _____ Date: _____

PARTNERS IN PLASTIC SURGERY OF WEST MICHIGAN

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Insurance Information

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST FOR COPYING.

Primary Insurance Company: _____

Subscriber's Name: _____ Relation to Patient: _____

Subscriber's Address: _____

Subscriber's Birthdate: _____ Subscriber's SSN: _____

Subscriber's Employer: _____ Subscriber's Phone: _____

Secondary Insurance Company: _____

Subscriber's Name: _____ Relation to Patient: _____

Subscriber's Address: _____

Subscriber's Birthdate: _____ Subscriber's SSN: _____

Subscriber's Employer: _____ Subscriber's Phone: _____

Is this a work-related injury? ☐Yes ☐No Is this an auto-related injury? ☐Yes ☐No

If yes to either of the above, where did injury occur? _____

If yes to either of the above, on what date did injury occur? _____

Physician Information

Please provide information about the physician(s) who provide care to you:

Primary Care or Family Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

I have authorized my doctor to correspond with the physician(s) listed above concerning my condition and any treatment plan that may be developed. ☐Yes ☐No

If no, please list the reason(s) you do not wish your doctor to correspond with your other physicians: _____

_____

Patient's Signature: _____ Date_____

PARTNERS IN PLASTIC SURGERY OF WEST MICHIGAN

Consents

1) **Consent for general treatment.** I request and authorize healthcare services to be provided by Partners in Plastic Surgery and members of its clinical staff.

2) **No representation for guarantees.** I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no oral or written representations or guarantees have been made to me as to the results of any diagnosis, treatment, and medical care that I (or the patient, if a minor) may receive as a patient at Partners in Plastic Surgery.

3) **Teaching facility.** I am aware that Partners in Plastic Surgery operates or assists in teaching programs in a number of health care professions and participates in approved medical research. I consent to the observation of my diagnosis and treatment and the review of my records for purposes of providing an essential part of these programs. I understand that this will be done with the utmost respect for my confidentiality and any identifying information shall not be published without my consent.

4) **Release of information.** I hereby authorize Partners in Plastic Surgery, its agents, and employees to release copies of my medical records, including information from prior treating physicians, x-rays, reports, and information about substance abuse treatment, mental illness, HIV infection, Acquired Immunodeficiency Syndrome, venereal disease or tuberculosis.

    a. to any governmental agency, medical service organization, insurance company, auditing agency engaged by Partners in Plastic Surgery or a third party payer, employer or physician for the purpose of processing any claims for benefits.

    b. to any physician or health care facility to which I, the patient, may be referred to for the purpose of continued patient care.

    c. to the physician/facility who has referred me to Partners in Plastic Surgery.

5) **HIV testing.** You are hereby notified pursuant to Michigan Law, that you may be tested for the presence of HIV, HIV antibody, Hepatitis B and Hepatitis C with or without your consent if any professional or other health facility employee sustains a needle stick, mucous membrane, or open wound exposure to your blood or other body fluids. This test is permitted by Michigan Law and is for your protection as well as the protection of the healthcare professionals at Partners in Plastic Surgery.

6) **Insurance coverage.** I hereby authorize Partners in Plastic Surgery to file and pursue a claim for payment of my charges with my insurance carrier as specified now or requested later. I authorize release of information to all my insurance companies. I understand that I am financially responsible for any balance not covered by my insurance. I also understand that Partners in Plastic Surgery may or may not participate with my current insurance carrier.

THIS RELEASE IS SUBJECT TO WRITTEN REVOCATION AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. THE UNDERSIGNED RELEASES **PARTNERS IN PLASTIC SURGERY** FROM ALL LEGAL RESPONSIBILITY OF LIABILITY THAT MAY ARISE FROM THIS AUTHORIZATION.

I hereby certify that I have read this form or it was read to me and that I fully understand the contents of this form.

Patient Signature: _____ Date: _____

PARTNERS IN PLASTIC SURGERY OF WEST MICHIGAN

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Height: _____

Age: _____ Weight: _____

To your knowledge, do you **now** or have you ever **had** any of the following?

No	Yes	
		AIDS
		Anemia
		Anxiety
		Arthritis
		Asthma
		Auto-Immune Disease
		Bleeding Disorders
		Blood Clots
		Blood Transfusion
		Bone Fractures
		Breast Cancer
		Bruise/Bleed Easily
		Cancer
		Caps/Dentures/Bridges
		Chest Pain / tightness
		Connective Tissue Disease
		COPD
		Crohn's Disease/Colitis
		Depression
		Diabetes
		Eczema
		Emphysema
		Facial Fractures
		Fainting Spells
		Frequent Nose Bleeds
		Head Injury
		Headaches/Migraines
		Heart Attack
		Heart Disease
		Heart Failure
		Heart Murmur
		Hepatitis
		Herpes
		High Blood Pressure
		High Cholesterol
		HIV Positive
		Hives

No	Yes	
		Intertrigo (rashes/skin irritation)
		Irregular Heart Beats
		Kidney Stones
		Liver Disease
		Loose or Missing Teeth
		Lupus
		Lyme Disease
		Mitral Valve Prolapse
		Multiple Sclerosis
		Obesity
		Pacemaker
		Phlebitis
		Polio/Meningitis
		Post-traumatic Stress Disorder
		Psoriasis
		Pulmonary Embolism
		Rheumatic Fever
		Rheumatoid arthritis
		Scoliosis
		Seizures
		Shortness of Breath
		Skin Cancer
		Skin Disease
		Sleep Apnea
		Stroke
		Thyroid Problems
		Tuberculosis
		Ulcers
		Urinary Tract Infection
		Weight Loss
		Xray Therapy
		OTHER problems (not listed)

Reviewed by (nurse initials) / Date _____

PARTNERS IN PLASTIC SURGERY OF WEST MICHIGAN

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Medications

Please list all medications (prescription and non-prescription) you are presently taking (include dosage and frequency) Be sure to include vitamins and herbal supplements, i.e. Fish Oil, Garlic, Ginkgo, Chamomile, St. John's Wort, etc.

☐ If none, please check.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List any medication allergies:

☐ If none, please check.

Name of medication:	Reaction:

Do you have allergies to Latex? ☐**Yes** ☐**No** Do you have allergies to Adhesives? ☐**Yes** ☐**No**

Please list all surgeries and major hospitalizations:

☐ If none, please check.

Description of procedure: Date of procedure:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Reviewed by (nurse initials) / Date _____

PARTNERS IN PLASTIC SURGERY OF WEST MICHIGAN

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Family Medical History

Have any family members suffered from any of the conditions listed below?

☐ Adopted – family history unknown.

No	Yes		Relation to you
		Breast Cancer	
		Cancer (please specify what type)	
		Diabetes	
		Heart Disease/ Stroke/ Heart Attack	
		High Blood Pressure	
		Lung Disease/ Asthma/ Emphysema	
		Malignant Hyperthermia	
		Rheumatoid Arthritis/ Lupus/ Fibromyalgia	
		OTHER	

Social History

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Do you have children? ☐Yes ☐No If yes, how many? _____ Their ages? _____

Occupation:_____

Do you consume alcohol? ☐Yes ☐No If yes, how many days per week? _____

Do you smoke cigarettes or use tobacco products? ☐Yes ☐No

If yes, how many cigarettes per day? _____

If no, have you ever smoked or used tobacco products? ☐Yes ☐No

Patient's Signature_____ **Date** _____

Physician's Signature_____ **Date** _____

Reviewed by (nurse initials) / Date _____

PARTNERS IN PLASTIC SURGERY OF WEST MICHIGAN

DIRECTIONS TO OUR OFFICE

We are located in the East/South 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 red brick building located behind Lake Michigan Credit Union. 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 next light onto EAST PARIS.
- Turn LEFT at 2nd light onto LAKE DRIVE.
- Take FIRST DRIVE on the RIGHT.
- We are in the building behind Lake Michigan Credit Union.

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 next light onto EAST PARIS.
- Turn LEFT at 2nd light onto LAKE DRIVE.
- Take FIRST DRIVE on the RIGHT.
- We are in the building behind Lake Michigan Credit Union.

Directions from the WEST (the shore of Lake Michigan)

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

Office Address: Partners in Plastic Surgery
4070 Lake Drive Suite 202
Grand Rapids, MI 49546
(616) 464-4420