PARTNERS IN PLASTIC SURGERY OF WEST MICHIGAN

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

Patient Name: _____ Preferred Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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

Email address: _____

Gender at birth: ☐Male ☐Female ☐Other: _____ SSN: _____

Gender Identity: ☐Male ☐Female ☐Other: _____ Birthdate: _____

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 #: _____

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

Preferred Language: _____

Reason for visit: _____

Type of Visit (check all that apply): ☐Insurance ☐Cosmetic ☐Gender Identity

Other Information

In Case of Emergency, who should we notify? _____

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

How did you hear about us?

☐Physician: _____ ☐Friend: _____

☐Website: _____ ☐Other: _____

Patient's Signature: _____ **Date:** _____

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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understand that this will be done with the utmost respect for my confidentiality and any identifying information shall not be published without my consent.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.

7) **No-show / Cancellation / Reschedule policy.** Failure to give at least a 24-hour notice when cancelling or rescheduling an appointment will result in a $25 no-show fee. You will be billed directly for this charge, and it is not reimbursable by your insurance company.

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's 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? (Check all that apply.)

	ADD / ADHD
	AIDS
	Anemia
	Anxiety
	Arthritis
	Asthma
	Auto-Immune Disease
	Bleeding Disorders
	Blood Clots / Pulmonary Emboli
	Blood Transfusion
	Bone Fractures
	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
	GERD / Heartburn
	Head Injury
	Headaches / Migraines
	Heart Attack
	Heart Disease
	Heart Failure
	Heart Murmur
	Hepatitis
	Herpes
	High Blood Pressure
	High Cholesterol

	HIV Positive
	Hives
	Intertrigo (rashes / skin irritation)
	Irregular Heart Beats
	Liver Disease
	Loose or Missing Teeth
	Lupus
	Lyme Disease
	Malignant Hyperthermia
	Mitral Valve Prolapse
	MRSA
	Multiple Miscarriages
	Multiple Sclerosis
	Obesity
	Pacemaker
	Phlebitis
	Polio / Meningitis
	Post-Traumatic Stress Disorder
	Psoriasis
	Radiation Therapy
	Rheumatic Fever
	Rheumatoid Arthritis
	Scoliosis
	Seizures
	Shortness of Breath
	Skin Disease
	Sleep Apnea
	Stroke
	Thyroid Disorder
	Tuberculosis
	Ulcers
	Urinary Tract Infection
	Weight Loss
	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 over-the-counter medications** such as vitamins and herbal supplements.

☐ If none, please check.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Preferred pharmacy: _____

Pharmacy phone #: _____ **Pharmacy fax #:** _____

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? (Check all that apply.)

☐ Adopted – family history unknown.

		Relation to you
	Breast Cancer	
	Cancer (please specify what type)	
	Diabetes	
	Heart Disease / Stroke / Heart Attack	
	High Blood Pressure	
	Blood Clots / Pulmonary Emboli	
	Lung Disease / Asthma/ Emphysema	
	Malignant Hyperthermia	
	Rheumatoid Arthritis / Lupus / Fibromyalgia	
	OTHER	

Social History

Occupation: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

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

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

Do you smoke cigarettes or use tobacco products? (including e-cigarettes) ☐Yes ☐No

If yes, how many cigarettes per day? _____

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

Do you have any religious or ethical concerns regarding surgery or blood transfusions? If so, please explain.

_____

_____

Patient's Signature: _____ **Date:** _____

Physician's Signature: _____ **Date:** _____

Reviewed by (nurse initials) / Date: _____