



## Cancellation Policy

Scheduling time for appointments and procedures takes planning and coordination. We understand that situations occur so if you anticipate not being able to make your scheduled appointment please let us know at least 24 hours beforehand. Failure to cancel your appointment before the 24 hour cancellation window or “no shows” will result in a twenty five (\$25) fee.

I have read and understand the cancellation policy:

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Patient Signature

Date

# IOWA PLASTIC SURGERY PATIENT INFORMATION

Patients Name \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_  
Street City State Zip Code

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Email Address \_\_\_\_\_

Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Gender: M F Marital Status: S M D W Spouses Name \_\_\_\_\_

Patients Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Dept \_\_\_\_\_ Phone \_\_\_\_\_ May we call you at work?  Yes  No

Emergency Contact (not in your household) \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

If Minor: Name of responsible party \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ SS# \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Reason for Consultation \_\_\_\_\_

Personal Injury  Yes  No Date of Injury \_\_\_\_\_ Work Related Injury  Yes  No Date of Injury \_\_\_\_\_

Name of Attorney Handling this accident/injury \_\_\_\_\_ Phone \_\_\_\_\_

Primary Health Insurance Company (Provide card to receptionist) \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Employer \_\_\_\_\_

Referral Required:  Yes  No Co-pay:  Yes  No Amount of co-pay \$ \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Birth Date \_\_\_\_\_ SS # \_\_\_\_\_

Secondary Health Insurance Company (Provide card to receptionist) \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Employer \_\_\_\_\_

Referral Required:  Yes  No Co-pay:  Yes  No Amount of co-pay \$ \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Birth Date \_\_\_\_\_ SS # \_\_\_\_\_

I understand that co-pay and deductible charges are payable at the time service is rendered. Initial \_\_\_\_\_

I authorize Iowa Plastic Surgery (IPS) to bill my insurance company.  Yes  No

I assign all insurance payments directly to IPS.  Yes  No

I agree to pay all charges in a timely manner, regardless of assignment of benefits. Initial \_\_\_\_\_

I understand I must notify IPS, should my insurance company require a referral, 2nd opinion or pre-authorization. Initial \_\_\_\_\_

I understand that I am responsible for all charges should my insurance company deny a claim. Initial \_\_\_\_\_

I authorize IPS to release my medical information to insurance companies, third party payers and/or hospitals/physicians that they have referred me to.  Yes  No

I understand that I have the right to refuse care, treatment and/or services. Initial \_\_\_\_\_

I am aware of and understand HIPAA privacy regulations. I understand I may request a copy of the IPS Privacy policy at any time during my treatment. Initial \_\_\_\_\_

I agree to be photographed and agree that the photographs will remain the property of IPS. I give Permission for these to be used for insurance payment and approval if applicable. If I give further permission, these pictures may be used for educational and demonstration purposes including publication. I understand I will not be identified by name. Initial \_\_\_\_\_

I authorize IPS to contact me by email or land mail for promotions.  Yes  No

**I authorize IPS to notify me of appointments, surgery and/or follow up care via text/phone/e-mail or U.S. mail**  Yes  No

Signature \_\_\_\_\_ Date \_\_\_\_\_

# MEDICAL HISTORY

Patient's Name \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Name of Family Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

Do you take aspirin, ibuprofen or similar medications?  Yes  No

List Drug Sensitivities and/or allergies with reactions: \_\_\_\_\_ None (circle if none)

Medications taken with dosage, including herbal medications and supplements: \_\_\_\_\_

Females: Are you currently pregnant?  Yes  No Last menstrual date? \_\_\_\_\_

List date(s) of childbirth(s) \_\_\_\_\_

List all previous surgeries with dates: \_\_\_\_\_

List all other hospitalizations with illnesses and year: \_\_\_\_\_

Do you use nicotine?  Yes  No What type? \_\_\_\_\_ How much? \_\_\_\_\_

Do you consume alcohol?  Yes  No How much? \_\_\_\_\_

If necessary, will you accept a blood transfusion?  Yes  No

Do you now or have you ever had:

- |            |  |                        |  |                  |  |
|------------|--|------------------------|--|------------------|--|
| Anemia     | <input type="checkbox"/> Yes <input type="checkbox"/> No                     | Chronic Pain Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes   | <input type="checkbox"/> Yes <input type="checkbox"/> No                     | Epilepsy or Seizures   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Easy Bruising    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma     | <input type="checkbox"/> Yes <input type="checkbox"/> No                     | Immune disorder/ HIV   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Addiction  | <input type="checkbox"/> Yes <input type="checkbox"/> No                     | High Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Ulcers   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis  | <input type="checkbox"/> Yes <input type="checkbox"/> No                     | Bladder infections     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma   | <input type="checkbox"/> Yes <input type="checkbox"/> No                     | Blood Clots in Legs    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema/COPD   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Counseling | <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, see below) |                        |  |                  |  |

Regarding Counseling: Counselor/Physician Name, Date, and Nature of Counseling

**I attest that these statements regarding my medical history are true to the best of my knowledge.**

Signature \_\_\_\_\_ Date \_\_\_\_\_