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	□ Yes	□ No	Chronic Pain Disorders	□ Yes	□ No	Heart Disease	□ Yes	□ No
Diabetes	□ Yes	□ No	Epilepsy or Seizures	□ Yes	□ No	Easy Bruising	□ Yes	□ No
Asthma	□ Yes	□ No	Immune disorder/ HIV	□ Yes	□ No	Kidney Disease	□ Yes	□ No
Addiction	□ Yes	□ No	High Blood Pressure	□ Yes	□ No	Stomach Ulcers	□ Yes	□ No
Hepatitis	□ Yes	□ No	Bladder infections	□ Yes	□ No	Thyroid Problems	□ Yes	□ No
Glaucoma	□ Yes	□ No	Blood Clots in Legs	□ Yes	□ No	Emphysema/COPD	□ Yes	□ No
Counseling	□ Yes	□ 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 _____

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:

_____

Patient Signature Date