

Patient Information

Fill in or correct all fields

Patient's Name

First

Middle

Last

Address

Street & Apt #

City

State

Zip

Home Phone

Cell Phone

Other Phone

Any restrictions for contacting you? No Yes

If yes, contact restrictions: _____

Email:

Drivers License # and State

Age

Birthdate

Gender

Female

Male

Marital Status:

Single

Married to:

Other:

Patient's Employer

Occupation

Work Phone

Ext:

Is it okay to call you at work?

Yes

No

Address

Street & Suite #

City

State

Zip

Responsible Party (if different from patient):

Name of spouse or parent if Patient is a minor _____

Relationship to Patient _____

Address

Home Phone

Emergency Contact

(Not in your household)

Relationship to Patient _____

Home Phone

Cell Phone

Other Phone

Reason for today's visit

How did you hear about Dr. Smart?

Frisco Style

Plano Profile

McKinney Woman

Southern Vanity

D Beauty

TV News

Salon

Facebook

www.kensmartmd.com

Other: _____

Friend/Relative: _____

Doctor: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

Payment Policy: Payment is due in full at the time services are rendered.

Assignment of Benefits: I hereby assign all medical and/or surgical benefits to which I am entitled, including private insurance and any other health plans, to Frisco Plastic Surgery, P.A.. I transfer my title of reimbursement from my insurance company to Dr. Smart of Frisco Plastic Surgery, P.A.. I authorize Dr. Smart to bill my insurance company for medically necessary services. I authorize my insurance claim form to be sent via electronic filing. I authorize said assignee to release all information necessary to secure payment. I authorize the release of my medical records or insurance claims to be sent via fax. **Regardless of insurance coverage, I am responsible to pay any and all charges that exceed or that are not covered by insurance.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signature

Date

6898 Lebanon Rd. Suite 102 , Frisco, TX 75034

Health Information as of _____ (enter today's date)
 (Please Print Legibly & Fill In or Correct All Fields)

Patient:				
DOB	Age	Marital Status	Weight	lbs
What surgery are you considering?			Height	ft in

DO YOU NOW OR HAVE YOU EVER HAD..... (You must circle an answer for each individual item)

Heart Trouble	Yes	No
Heart Attack	Yes	No
Heart Pain	Yes	No
Palpitation or Irregular Pulse	Yes	No
Extra Heart Beats	Yes	No
Stroke	Yes	No
Hypertension	Yes	No
Blood Pressure Abnormalities	Yes	No
Abnormal EKG	Yes	No
Rheumatic Fever	Yes	No
Dropsy or Heart Failure	Yes	No
Digitalis Treatment	Yes	No
Shortness of Breath	Yes	No
Chest Pain	Yes	No
Asthma	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Tuberculosis	Yes	No
Smokers Cough	Yes	No
Emphysema	Yes	No
Coughing or Spitting of Blood	Yes	No
Hay Fever	Yes	No
Major Allergies	Yes	No
Palsy or Paralysis	Yes	No
Nervous Breakdown	Yes	No
Nervous Disorder	Yes	No
Insomnia	Yes	No
Drug Habit	Yes	No
Self-Destructive Tendencies	Yes	No
Psychiatric Hospitalization or Care	Yes	No
Thyroid Problems	Yes	No
Kidney or Renal Disease	Yes	No
Heart murmur	Yes	No
Piercing other than the ears	Yes	No
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No
Missed or irregular last menstrual period	Yes	No
Family history of cancer, heart trouble, stroke	Yes	No

Glaucoma or Eye Problems	Yes	No
Visual Disturbances	Yes	No
Error in Refraction	Yes	No
Other Eye Problems	Yes	No
Hepatitis	Yes	No
Yellow Jaundice	Yes	No
Gallstones or Gallbladder Trouble	Yes	No
Cirrhosis of the Liver	Yes	No
Alcoholism or Drug Dependency	Yes	No
Esophageal Varices	Yes	No
Frequent Indigestion	Yes	No
Ulcers	Yes	No
Gastritis	Yes	No
Colitis	Yes	No
Problem Constipation	Yes	No
Vomiting Blood	Yes	No
Tarry or Bloody Bowel Movements	Yes	No
Hemorrhoids	Yes	No
Goiter or Thyroid Disorders	Yes	No
Diabetes	Yes	No
Skin Disorders	Yes	No
Arthritis	Yes	No
Fracture of Neck or Spine	Yes	No
Bleeding Tendency or Disorder	Yes	No
Abnormal Bleeding after Tooth Extraction	Yes	No
Airway Obstruction (Nasal)	Yes	No
Breast Cysts, Tumors, Abscesses	Yes	No
Nipple Discharge (Apart from Normal Lactation)	Yes	No
Kidney Disorder	Yes	No
Blood Transfusion	Yes	No
Seizures or convulsions or fainting spells	Yes	No
Black outs	Yes	No
Dentures, bridges, capped teeth or crowns	Yes	No
Loose teeth	Yes	No
Cosmetic bonding to teeth	Yes	No
Any family members with bleeding problems	Yes	No
Any family members with anesthesia problems	Yes	No

1. **Please list all present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. **Include over-the-counter medications.**

2. Do you have an allergic reaction to any medication? Yes No Which? _____

3. Do you react abnormally to any medication? Yes No Which? _____
4. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?
 Yes No If yes, when and where? _____
5. Have you ever been on cortisone or steroid treatment? Yes No When? _____
6. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?
 Yes No If so, how much? _____
7. Do you smoke? Yes No If so, how much? _____ For how long? _____
8. Are you pregnant? Yes No When was you last normal menstrual period? _____
9. How many pregnancies? _____ Births? _____ Breast Fed? Yes No How long? _____
CHILDREN (list names and ages/birthdays): _____

10. When was your last physical exam? _____ By whom? _____
11. When was your last eye examination? _____ By whom? _____
12. When and where was your last chest x-ray? _____ EKG? _____
13. Who is your personal physician, if any? _____ Please list all physicians presently caring for you.

14. Have you ever been under psychiatric care? Yes No When? _____ Why? _____
15. Have you had any recent blood work done? Yes No Where? _____
16. Is there anything else you think the doctor should know? _____

17. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:
SURGICAL OPERATIONS (include where, when and why for each surgery): _____

HOSPITALIZATIONS (include where, when and why for each admission): _____

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____

Insurance Information & Authorization

(Please Print Legibly & Sign)

Patient's Name _____
First Middle Last

Primary Insurance Company _____

Insurance Phone Number: _____

Claim's Address: _____

Policy Number : _____ Group Number : _____

Policyholder's Information:

Name _____ Birthdate ____ / ____ / ____

Employer _____ Relationship to Patient _____

Does this insurance required a referral? Yes No Copay Amount \$ _____

Secondary Insurance Company _____

Insurance Phone Number: _____

Claim's Address: _____

Policy Number : _____ Group Number : _____

Policyholder's Information:

Name _____ Birthdate ____ / ____ / ____

Employer _____ Relationship to Patient _____

Does this insurance required a referral? Yes No Copay Amount \$ _____

Is this visit due to any type of accident? No Yes: Date of Accident _____

All Insurance Patients

I request that payment of authorized benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services.

Beneficiary Signature _____ Date _____

Medicare Patients Only

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____