PATIENT INFORMATION

DATE: _____

Name: (Full Legal):First _____ Middle Initial ____Last _____

Preferred or Nickname: _____ **Gender:** M F Other **Date of Birth**: _____ Age: _____

Race: *Check all that apply* ☐White ☐Asian ☐Black or African American ☐Native Hawaiian /Other Pacific Islander ☐American Indian/Alaska Native

Marital Status ☐Single ☐Married ☐Partner ☐Widowed ☐Divorced ☐Other

Ethnicity: ☐Not Hispanic/Not Latino ☐Hispanic or Latino

Preferred or Primary Language: (please check box) ☐English ☐ Other specify language: _____

Address: Street _____ Apt/Unit # _____

City _____ State _____ Zip _____

Please indicate your primary/preferred phone number to reach you .
This should be a number where we can leave a DETAILED MESSAGE.

Primary or Preferred Phone Number: ( ) _____ ☐Home ☐Work ☐Cell ☐Other_____

Alternative Phone numbers

Other phone numbers: ( ) _____ ☐Home ☐Work ☐Cell ☐Other_____

Other phone numbers: ( ) _____ ☐Home ☐Work ☐Cell ☐Other_____

Personal Email address: (required for patient portal) _____

Do you want to be registered for our patient portal to access your health information: ☐ Yes ☐ No

Communication preference: ☐Phone ☐Mail ☐Messages via patient portal (requires email address and registration for portal)

If the patient is a **minor or has a legal guardian**, please provide the responsible party's information below:

Responsible Party Name: _____ **Relationship to patient**: _____

☐ Address same as above

Address: Street _____ Apt/Unit# _____ Date of Birth: _____

City _____ State _____ Zip _____

Phone Number: ( ) _____ ☐ Home ☐ Work ☐ Cell ☐ Other _____

Emergency Contact Information

Name: _____ Relationship to patient: _____

Contact phone numbers: ( )_____ Alternate Number: ( )_____

Preferred Pharmacy Information

Store Name: _____ Phone #: ( ) _____

Address: _____ City: _____ State: _____ Zip: _____

Please complete additional information and signatures on the back of this form.

If you are being seen for a **worker's compensation injury** or some other type of liability claim (example: **auto or home accident**) please see the receptionist for an additional form and do not complete the back of this form.

INSURANCE INFORMATION

The receptionist will also make a copy of your insurance card/s. The insurance subscriber information is not provided on your identification card and is needed to file your claims to your insurance company.

Primary Insurance Company Name: _____

Insurance Subscriber Name: _____ Birthdate: _____

Patient Relationship to the insurance subscriber: _____

Secondary Insurance Company Name: _____

Insurance Subscriber Name: _____ Birthdate: _____

Patient Relationship to the insurance subscriber: _____

ASSIGNMENT OF BENEFITS and INSURANCE INFORMATION RELEASE

I authorize payment of medical benefits to Midwest Plastic Surgery for services rendered to myself or dependents. I authorize Midwest Plastic Surgery to release on behalf of myself or my dependents any information required or requested by my insurance carrier or other reimbursement entities for the purpose of payment. I understand that I am responsible for any amount my insurance company indicates as patient responsibility.

Signature: _____ Date: _____

RELEASE OF INFORMATION for treatment

I authorize Midwest Plastic Surgery to release on behalf of myself or my dependents any information required for treatment to my health care providers or other medical entities involved in my care . I also authorize Midwest Plastic Surgery to release limited health information to other entities for legitimate business activities such as patient experience surveys.

Signature: _____ Date: _____

RELEASE OF INFORMATION for marketing purposes

I authorize Midwest Plastic Surgery to use my documented demographic information to contact myself or dependents with marketing information, materials, or offers for the practice and physicians.

Signature: _____ Date:_____

MEDICATION HISTORY

I authorize Midwest Plastic Surgery to review any medication history that may be available through an electronic prescription database.

Signature: _____ Date:_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Midwest Plastic Surgery's **HIPAA Notice of Privacy Practices** is available for you to review. It is presented with this form in the office. Please request a copy of the notice from the receptionist or download it from our website (www.midwestplasticsurgery.net) if you complete this form in advance.

I acknowledge that I have been offered the HIPAA Notice of Privacy Practices for Midwest Plastic Surgery.

Signature: _____ Date: _____

Relationship to Patient: _____

HEALTH HISTORY QUESTIONNAIRE DATE: _____

PATIENTS NAME_____**PREFERRED NAME**_____

AGE_____ **(if minor, who is completing form)** _____

OCCUPATION_____

REFERRING DOCTOR/SOURCE (circle or fill in): Friend/Family Internet Top Docs/Mpls-St Paul Magazine Self-Referred Attorney another patient Other Clinic/Provider(name):_____

PRIMARY CARE PHYSICIAN_____

REASON FOR BEING SEEN TODAY_____

Circle the conditions that you have/had

Asthma/COPD	**Diabetes**	**Depression**	**Breast cancer**
Sleep Apnea / CPAP	**Difficult airway**	**High blood pressure**	**Anxiety / Bipolar**
Heart disease / Heart attack	**HIV / AIDS**	**Kidney dialysis**	**Seizure disorder**
Hypothyroidism	**Chemotherapy**	**Skin cancer**	**Reflux / ulcers**
Atrial Fibrillation	**Blood clots**	**Radiation therapy**	**Herpes / cold sores**
Pacemaker / defibrillator	**Hepatitis**	**Stroke**	**High cholesterol**

For the following questions please use the back of this sheet if you need additional space

Please list any other medical problems that you have:

_____

Please list any of the above conditions which have affected your family members:

_____

Please list all previous surgeries (including cosmetic surgeries):

_____

_____

List all medications you are taking, include prescription and over the counter or herbal medications:

_____

_____

Do you take aspirin, ibuprofen, steroids/cortisone/prednisone, Coumadin or blood thinners:

_____

List any allergies or sensitivities and reaction (include medication, food, latex, anesthesia related problems etc.):

_____

Circle your answers below

Do you use alcohol? YES / NO

Do you use caffeine? YES / NO

Do you use recreation drugs? YES / NO

Smoking History (circle your answer)

Never smoker

Former smoker

Current some day smoker ___ amount

Current every day smoker ___ amount

Women only:

Are you pregnant or trying to conceive? YES / NO

Number of pregnancies: _____ Number of children: _____

Have you had a mammogram? YES / NO If yes date of most recent mammogram_____

OFFICE USE

HEIGHT_____ WEIGHT _____ BP_____ P_____BMI_____