

Arkansas Plastic Surgery

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Appointment Date _____

INFORMATION FOR CASE HISTORY FILE

Patient Information

Patient's Name: _____ SS# _____
First Middle Last

Date of Birth: _____ Patient's Age: _____ Patient's Sex: _____

Race: _____ Please Circle: Married Single

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

Home Phone: _____ Cell Phone: _____ Alt. Phone: _____

Employer: _____ Business Address: _____ Bus. Phone: _____

May we leave a voice message at any of your phones? _____

May we contact you by e-mail? E-mail address: _____

May we disclose your personal health information to any friends/family members: Yes No
 If so, please list name(s): _____

Name of Primary Care Physician: _____

Emergency Contact Information (Please list nearest relative not living at the same address as patient.)

Relative's Name and Address: _____

Relationship to Patient: _____ Phone: _____

How Were You Referred?

If Doctor, Referring Dr's Name & Address: _____
 Phone Number: _____

Friend/Former Patient YES NO _____
Please give name of patient so we can thank them!

| | | | | |
|--------------|-----|----|-------------------|-------|
| Website | YES | NO | Name of Website | _____ |
| Magazine | YES | NO | Name of Magazine: | _____ |
| Television | YES | NO | Station: | _____ |
| Newspaper | YES | NO | Name of Ad: | _____ |
| Other Source | YES | NO | Name: | _____ |

Reason for Consult: _____

Spouse Information:

Name: _____ SS#: _____ D.O.B. _____

Employer: _____

Business Address: _____ Bus. Phone: _____

Parent Info (This section applies when the patient is a minor and parent is financially responsible)

Name: _____ SS#: _____ D.O.B. _____

Employer: _____

Business Address: _____ Business Phone: _____

Insurance Information (IF NOT INSURANCE-RELATED, SKIP AND GO TO NEXT PAGE)

Primary Insurance Carrier

Insurance Company Name: _____ Claims Address: _____

Insurance Company Phone Number: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Number: _____ Group Number: _____

Subscriber's SS#: _____ Subscriber's DOB: _____ Employer's Name:

Secondary Insurance Carrier

Insurance Company Name: _____ Claims Address: _____

Insurance Company Phone Number: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Number: _____ Group Number: _____

Subscriber's SS#: _____ Subscriber's DOB: _____ Employer's Name:

Other Insurance Carrier

Insurance Company Name: _____ Claims Address: _____

Insurance Company Phone Number: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Number: _____ Group Number: _____

Subscriber's SS#: _____ Subscriber's DOB: _____ Employer's Name:

ARKANSAS PLASTIC SURGERY

Medical History Questionnaire

NAME _____ DATE OF BIRTH _____

Pharmacy name, location & phone number _____

Are you allergic to any medicines? Y or N If so, what _____

Are you currently taking any medications daily? _____ If so, please list: _____

Have you had surgery? If so, what procedure and when? _____

If you are a breast reconstruction patient, did you have chemotherapy or radiation? _____

Do you have a history of any of the following:

_____ Diabetes _____ Liver Disease

_____ Emphysema _____ Rheumatic Heart Disease

_____ Pneumonia _____ Kidney Disease

_____ High Blood Pressure _____ Psychiatric Disorders

Do you have a history of developing fever blisters? Y or N (even if only 1 occurrence during the course of your life)

Do you have any other health problems? _____

If so, what and who treats you for them? _____

Do you smoke? _____ If so, how much? _____

Height _____ Weight _____ Is your weight currently stable? _____

If deemed necessary by my surgeon, I agree to the testing for the HIV virus (AIDS). Y or N

MEN ONLY:

Have you ever had prostate trouble? Y or N Explain _____

Have you ever had a hernia? Y or N Explain _____

DO YOU HAVE, OR HAVE YOU EVER HAD:

- | | |
|---|--|
| <input type="checkbox"/> AIDS OR HIV | <input type="checkbox"/> HIGH BLOOD PRESSURE |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> IRREGULAR HEARTBEAT |
| <input type="checkbox"/> BLEEDING TENDENCY | <input type="checkbox"/> LIVER DISEASE |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> LUNG DISEASE |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> LOSS OF WEIGHT |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> MIGRAINE |
| <input type="checkbox"/> EMOTIONAL PROBLEMS | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> SICKLE CELL DISEASE |
| <input type="checkbox"/> EYE PROBLEMS | <input type="checkbox"/> STOMACH ULCERS |
| <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> HEART FAILURE | <input type="checkbox"/> THYROID PROBLEM |
| <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> ULCERS |

Do you have a history of any psychiatric illness or condition? _____ If yes, please explain: _____

Have you ever been hospitalized for any of the previous problems? _____ If yes, please explain: _____

HAS ANY BLOOD RELATIVE HAD:

Please circle all that apply and list relationship

- | | |
|-------------------------|--------------------------------|
| _____ Bleeding tendency | _____ Stroke |
| _____ Breast cancer | _____ High fever after surgery |
| _____ Other cancer | _____ Sickle cell disease |
| _____ Diabetes | |

SOCIAL HISTORY

- Do you smoke cigarettes, cigar or pipe? Y N Packs/day _____ for how many years _____
- Have you quit smoking? Y N Packs/day _____ for how many years _____
- Do you use a nicotine patch or gum? Y N
- Do you use smokeless tobacco? Y N
- Do you drink alcohol, wine or beer? Y N How much per week _____
- Have you ever injected recreational drugs? Y N What? _____

It is EXTREMELY important that you let us know if you are smoking. Severe surgical complications due to smoking can arise if we are not prepared for them. Smoking has a DETRIMENTAL EFFECT on wound healing. PLEASE POINT OUT YOUR SMOKING TO OUR DOCTORS FOR YOUR SAFETY!

WOMEN ONLY:

- Is there a chance you may be pregnant? Y N
- Have you had a recent bladder infection? Y N
- Do you still have regular menstrual periods? Y N
- Do you have menstrual problems? Y N Explain _____
- Have you ever taken birth control pills? Y N
- Have you ever used hormones: Y N When? _____
- Do you regularly have Pap smears? Y N Date of Last? _____

Number of pregnancies _____ Live Births _____ Miscarriages/terminations _____

Any problems with pregnancies? _____

Date of last breast exam _____ Results _____

Date of last mammogram _____ Results _____

To the best of my knowledge, the above information is correct.

SIGNATURE: _____ **DATE:** _____

RELEASE OF INFORMATION

PLEASE READ EACH CONSENT/AUTHORIZATION BELOW
AND SIGN AT THE BOTTOM OF THE PAGE

CONSENT FOR PHOTOGRAPHIC DOCUMENTATION

I consent to be photographed before, during, and after my treatment, operation, etc. recommended by Arkansas Plastic Surgery. These photographs shall be the property of Arkansas Plastic Surgery. I understand that every effort will be made to protect my identity unless I otherwise give Arkansas Plastic Surgery separate written permission to use my photographs for designated purposes.

CONSENT FOR COMMUNICATION

There are many ways to communicate with you. It is important to keep appointments and let us know if problems or issues arise. Methods of communicating include, telephone, texting, social media, pagers, answering service if available, e-mail, and regular mail. Please do not leave a message after hours or on weekends on the office answering machine if any urgent or emergent situation exists, as there is a delay in retrieving such messages. All attempts will be made to preserve your privacy in accordance with HIPAA rules. Please confirm below all acceptable ways of communicating with you:

| | |
|--------------------------|--|
| _____ Telephone | _____ Social Media (ie, Facebook, etc) |
| _____ Home (- -) | _____ Pager/Answering Service |
| _____ Work (- -) | _____ E-mail (@) |
| _____ Cell (- -) | _____ Regular Mail and Delivery |
| _____ Texting | |

CONSENT FOR SELF-PAY PATIENTS

I understand and agree that any and all charges incurred by me shall be paid in full to Arkansas Plastic Surgery.

CONSENT FOR CREDIT CARD, DEBIT CARD, FINANCING PAYMENTS

Services that are performed that are paid for with a credit card, debit card, or with financing are not eligible for post-surgical/post-care payment challenges. Arkansas Plastic Surgery encourages a complete post-op care and follow-up interaction to address any issues that might arise. I agree that this credit card, debit card, financing challenge agreement is irrevocable.

AUTHORIZATION FOR MEDICAL INFORMATION RELEASE AND CLAIM PAYMENT ASSIGNMENT OF INSURANCE

I hereby authorize Arkansas Plastic Surgery to release to my insurance company(ies) any and all information they may require concerning my case.

I hereby request and authorize my insurance company(ies) to pay directly to Arkansas Plastic Surgery all benefits due under said policy(ies) by reason of services rendered therein.

In making this assignment, I understand and agree that any unpaid balance not covered by my insurance will be paid by me.

A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature: _____ Date: _____

ARKANSAS PLASTIC SURGERY, P.A.
9500 Kanis Road, Suite 502
Little Rock, AR 72205

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT FORM**

I, _____, have received
Patient's Name

a copy of Arkansas Plastic Surgery's Notice of Privacy Practices.

Signature of Patient

Date