

## Patient Information

### PATIENT INFORMATION:

First Name: \_\_\_\_\_

Middle Name/Initial: \_\_\_\_\_

Last Name: \_\_\_\_\_

If you prefer to go by another name: \_\_\_\_\_

Gender: (circle) *Male* *Female*

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status: (circle) *Single* *Married* *Divorced* *Widowed*

*Under new government regulations relating to electronic records we are required to ask the following 3 questions. Although we are required to ask, you are not required to answer:*

Race: *American Indian* *Asian* *Black* *Hispanic* *White*

Ethnicity: \_\_\_\_\_

Preferred language: *English* *Spanish* *Other* \_\_\_\_\_

Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Other Phone: (\_\_\_\_\_) \_\_\_\_\_ Type: \_\_\_\_\_

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

*Please only include your email address if it is a confidential email & you are willing to have communications regarding your medical care sent to you by email. Your email address will not be given to others or used for solicitations. By indicating your email, you are hereby authorizing communications by email.*

### REFERRAL SOURCE:

How did you learn about our office?

Internet/website  A patient: \_\_\_\_\_

Another physician: \_\_\_\_\_

### RESPONSIBLE PARTY – WHO DO THE STATEMENTS GO TO?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Phone Contact: (\_\_\_\_\_) \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

### PRIMARY INSURANCE: Please provide the receptionist with a copy of your card to scan.

Insurance Company: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

Insured's Relationship to the Patient: \_\_\_\_\_

Policy ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insurance Phone: \_\_\_\_\_

### SECONDARY INSURANCE: Please provide the receptionist with a copy of your card to scan.

Insurance Company: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

Insured's Relationship to the Patient: \_\_\_\_\_

Policy ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insurance Phone: \_\_\_\_\_

### CONTACTS:

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

### PATIENT EMPLOYMENT:

Employer Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

### PHARMACY:

Pharmacy Name: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

## Medical History

Height: \_\_\_\_\_  
 Weight: \_\_\_\_\_

*To be completed by nurse/medical assistant:*  
 Temp: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_

Indicate if you have **ever** had or been treated for the following:

	Yes	No	Is this a current condition?	Date Began or diagnosed	Additional Notes
Alcoholism					
Allergy to local anesthetic					Type of reaction: _____
Anemia					
Arthritis					
Asthma					
Blood Disorder					
Cancer					Type: _____
Diabetes					Type: _____
Drug addiction					
Heart surgery					Type: _____ Dates: _____
Heart disease					Type: _____
Hepatitis A, B, or C					Type: _____
Heart attack/chest pain					
Hypertension / high blood pressure					
HIV+					
Keloids or scarring					
Kidney disease – acute renal failure					
Kidney disease – chronic renal failure					
Liver disease					
Lung disease					
Prolonged bleeding					
Psychiatric treatment					
Radiation treatment					Location: _____
Shortness of breath					
Skin cancer					Type: _____ Location: _____
Stroke/TIA					
Thyroid problems					
Ulcers (GI)					
Other					
Other					

**Surgical History: List all surgeries you have had and approximate dates**

- Mastectomy \_\_\_\_\_       Hysterectomy \_\_\_\_\_  
 Breast biopsy \_\_\_\_\_       C-section \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_

**Family History: Indicate if a member of your family has a history of:**

	Yes	No	Which family member(s)	Is that family member still alive?
Skin cancer				
Melanoma				
Breast cancer				
Ovarian cancer				
BRCA testing done?			Results: _____	

**Social History:**

Smoking:

 Never smoked Quit smoking: when \_\_\_\_\_ Currently smoke: # packs per day: \_\_\_\_\_

Alcohol drinking:

 Do not drink Socially, occasionally Amount per week: \_\_\_\_\_**Medications Currently Taking:** (attach additional page if necessary)

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Reason: \_\_\_\_\_  
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 Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Reason: \_\_\_\_\_

**Drug Allergies / Reactions:** \_\_\_\_\_**Reason for today's visit?** \_\_\_\_\_**Indicate if you are currently experiencing or being treated for any of the following:**

Note: Anything not marked will be considered something you are NOT currently experiencing or being treated for so please review carefully.

<b>General:</b>		<b>Cardiovascular:</b>		<b>Dermatologic:</b>	
chills		arrhythmia		Cellulites	
fatigue		chest pain/pressure		Intertrigo / rashes	
fever		edema/swelling of limbs		Keloid scarring	
insomnia		high blood pressure		Lipoma	
recent illness		dizziness		Melanoma	
recent weight gain		<b>Respiratory:</b>		Scarring	
recent weight loss		asthma		Skin cancer	
<b>Eyes:</b>		chest congestion		Sores/wounds	
eye redness/erythema		cough		<b>Neurologic:</b>	
eye pain		<b>Gastrointestinal:</b>		Dizziness	
eye tearing		Abdominal pain		Headache	
eye tearing		Constipation		Mental status change	
eyelid edema/swelling		Diarrhea		Paresis/paralysis	
eyelid pain		Gas/bloating		<b>Psychiatric:</b>	
vision change		Nausea		Alcohol abuse	
visual field obstruction		Vomiting		Anxiety	
<b>Ears/Nose/Throat:</b>		Swelling		Depression	
deviated septum		<b>Genitourinary/nephrology:</b>		Drug abuse	
facial pain		Acute renal failure		<b>Endocrine:</b>	
facial swelling		Chronic renal failure		Diabetes – type:	
nasal discharge		Hernia		<b>Hematologic:</b>	
nasal obstruction		Pregnancy		Abnormal bleeding/bruising	
nasal pain		<b>Musculoskeletal:</b>		Anemia	
nasal trauma		Limb pain			

Any other conditions you are currently experiencing or being treated for?: \_\_\_\_\_

**CONSENT:**

By my signature below I consent to the following:

**FINANCIAL CONSENT:** I hereby assign all medical benefits to which I am entitled to make direct payment to Texas Plastic Surgery Associates. I understand that I am responsible for payment of all co-pays, deductibles, or non-covered services at the conclusion of each visit. I understand that my insurance company may not cover certain services and that I may be responsible for payment of those services upon being billed.

**RELEASE OF RECORDS:** I authorize Dr. Duffy, Dr. McKane, and Texas Plastic Surgery Associates to disclose all or part of my medical &/or patient account records to my insurance company or association as may be necessary for the completion of any outstanding insurance claims, as well as to any treating physicians or healthcare providers involved in my or my child's medical care, including copies of records, CT scans, x-rays, and other medical records.

**TREATMENT CONSENT:** I (we) voluntarily request Dr. Frederick Duffy or Dr. Brice McKane as my physician and such associates as he may deem necessary to provide medical examination and appropriate treatment for my condition. I understand this examination and treatment may include in-office procedures as well as the possibility of surgical procedures scheduled at a hospital or surgery facility. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of any surgical, medical, and/or diagnostic procedures.

**ACKNOWLEDGEMENT NOTICE OF PRIVACY PRACTICES** Under federal HIPAA guidelines, all patients are to be provided with the opportunity to review and/or have a copy of a physician's Notice of Privacy Practices which explains how medical information will be used and disclosed. By my signature below I acknowledge having been made aware there is a copy in the waiting room, as well as one attached here for me to take, if I choose to do so. I understand I may request a copy or additional copies of this document at any time. I further authorize Dr. Duffy and Dr. McKane and such associates as he may deem necessary to download my medication history from my pharmacy/pharmacies if such history is available.

Patient/Legal Guardian Signature \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

**CONSENT FOR USE OF E-MAIL AND OTHER ELECTRONIC COMMUNICATIONS**

To better serve, and at the request of our patients, this office utilizes email and other electronic communication methods where appropriate for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at the main email address of [patients@texaspsa.com](mailto:patients@texaspsa.com) or at any office email address provided to you by staff. Please remember, however, that this form of communication is **not** appropriate for use in an emergency. The turnaround time for routine patient communications is typically 24-48 hours (business days). However, email service providers may delay message deliveries, and not all emails successfully arrive at their destinations. "Spam" and "Junk Mail" programs sometimes interfere with receipt of emails in a timely fashion. Furthermore, staff may not be in the office on the day an email is received which may further delay response. **If you require urgent or immediate attention, this method of communication is not appropriate.** If you need a response quickly, or if you do not hear from us within 24-48 hours of an email, please call our office.

When sending emails, please be sure to put your name and a return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by a reply email or an auto-reply feature so we can be sure you received any communications from our office. *All communications relating to diagnosis and treatment will be filed in your medical record.*

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email and other electronic communication, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that emails addressed to Dr. Duffy or Dr. McKane directly will be reviewed and possibly answered by staff and/or colleagues depending on the nature of the issue.

**By signing below I indicate 1) my understanding that this office will not be responsible for information loss or delay or breaches in confidentiality that are beyond reasonable office control; 2) my understanding that by communicating with this office in an electronic format and/or by providing my email address I am agreeing to communication regarding my condition and any possible procedures by email and agree the office may send medical related correspondence to me by email or electronic formats and may respond to any emails from me likewise; and 3) my agreement to the above email and electronic communication policy.**

\_\_\_\_\_  
Email address

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date