American Institute for Plastic Surgery
Surgery Center of Texas

PATIENT INFORMATION

Today's Date: ______________

Patient's Legal Name ____ **Nickname** ________________
Last First Middle

Date of Birth: ___/____/_____ **Age**_____ **SSN:**_____-_____-_____ **Height:**__' ___" **Weight:**____ **lbs**

Sex: ☐Male ☐Female **Marital Status:** S/ M/ D/ W **Primary Language** ____________________

Address: ____
Street & Apt # City State Zip

Phone **Privacy**
Home: (____) _____ - __________ ☐
Work: (____) _____ - __________ ☐
Cell: (____) _____ - __________ ☐
Fax: (____) _____ - __________ ☐

Emergency Contact, can we discuss your care?
Name: ____________________________ Y☐ N☐
Relationship: ________________________
Home: (____) _____ - __________
Work: (____) _____ - __________

E-mail ____________________________________ **Preferred Method of Contact** ________________

May we send you email correspondence? (Promotions, specials, appointments) Y☐ N☐

Occupation / Employer or school: ________________________/________________________________
☐ Full Time Employment ☐ Part Time Employment ☐ Retired
☐ Full Time Student ☐ Part Time Student ☐ Other

Tell us what procedures you are interested in? ____

Whom may we thank for referring you? ☐ Patient ☐ Physician ☐ Internet ☐Magazine ☐Radio ☐ Other

Name: ____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT- If other than patient:

Legal Name ____ **Relationship** ______________
Last First Middle

Date of Birth:___/____/______ **Age:**_____ **SSN:**____-____-____ **License #/State:**___________/_____

Sex: ☐ **Male** ☐ **Female** **Phone: H:**_______________ **W:**____________**Cell/Pager:**______________

Address: ____
Street & Apt # City State Zip

PRIMARY INSURANCE COMPANY:

Insurance Company:____ Phone #:______________________

Claim Address: ____

Insurance Plan Type: PPO HMO POS EPO Group #:__________________ ID#:____________________

Workers Comp Manager / Phone:____

PRIMARY CARE PHYSICIAN________________________________PH#: ______________________
☐I have a referral from my PCP ☐ I need a referral from my PCP

Updated Nov/11

American Institute for Plastic Surgery / Surgery Center of Texas

HEALTH HISTORY

(All information is strictly confidential)

Name________________________________ **Age**________ **Today's Date**________________

Reason For Visit____

For Injuries: Date of Injury ____________ **On the job?** ☐ **Yes** ☐ **No Occupation**________________________

Height:__' ___" **Weight:**______ **lbs. What is the most you have ever weighed:** ________**lbs**

PAST MEDICAL HISTORY

Please check if you have, or ever had any of the following conditions: ☐ **None**

Cardiovascular
- ☐ Anemia
- ☐ Angina / chest pain
- ☐ Arrhythmia
- ☐ Congestive heart failure
- ☐ Heart attack
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart valve disorder
- ☐ Pacemaker / Stent
- ☐ Rheumatic heart disease

Respiratory
- ☐ Asthma / Bronchitis
- ☐ COPD / Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis

Gastro-intestinal
- ☐ Liver disease
- ☐ GERD
- ☐ Hernia
- ☐ Hepatitis
- ☐ Peptic ulcers

Blood
- ☐ Bleeding disorders
- ☐ Blood transfusion
- ☐ DVT / Blood clots / Pulmonary Embolism

Neurologic
- ☐ Epilepsy
- ☐ Migraines
- ☐ Paralysis
- ☐ Stroke/ TIA

Mental Health
- ☐ Alcohol/ Drug dependency
- ☐ Anorexia /Bulimia
- ☐ Depression
- ☐ Psychiatric care
- ☐ Suicide attempt

Skin/ Skeletal
- ☐ Jaundice
- ☐ Skin disorder
- ☐ Arthritis
- ☐ Gout
- ☐ Fracture

Immune/Infection
- ☐ AIDS / HIV
- ☐ Herpes / fever blister
- ☐ Immune problem
- ☐ MRSA/ VRE
- ☐ Venereal disease

Endocrine
- ☐ Diabetes
- ☐ Thyroid disorders

Other
- ☐ Glaucoma
- ☐ Kidney disorders
- ☐ Impairment: Type____________
- ☐ Cancer: Type____________

Are you being treated for any other illness at this time? ☐ **Yes** ☐ **No. If yes, please explain:**

____

____

Date of Last Physical ________________ **Results** ______________________________

Have you ever had SURGERY? ☐ **Yes** ☐ **No** **If yes, please list:**

Have you, or a family member ever had a problem with anesthesia? ☐ **Yes** ☐ **No. If yes, please explain:**

____

Have you been diagnosed with a sleep disorder/sleep apnea? ☐ **Yes** ☐ **No**
Do you use a C-Pap Machine for your sleep disorder? ☐ **Yes** ☐ **No**

Do you have any DRUG ALLERGIES? ☐ **Yes** ☐ **No. If yes, please note name of drug and reaction:**

FAMILY HISTORY (Only list blood related relatives.) ☐ **None**

☐ Diabetes		☐ Blood Clots		☐ High Blood Pressure	
☐ Stroke		☐ Heart Disease		☐ Cancer/ type	
☐ Other					

LIST ALL MEDICATIONS YOU ARE TAKING WITH NAME AND DOSAGE: ☐ **No Meds**

		☐ Weight control	☐ Estrogen/ hormones
		☐ Accutane (past year)	☐ Chemotherapy
		☐ Antibiotics	☐ Antidepressants
		☐ Aspirin/ NSAID's	☐ Steroids
		☐ Blood thinners	☐ Vitamins/ supplements
		☐ Birth control	☐ Herbal/ homeopathics

Are you taking or have you ever taken recreational drugs? ☐ Yes ☐ No What type________________________________
Please give more details ____

Do you smoke?	☐Yes	☐No	Quit? _______	**How much?**____________________ # per day		
Do you drink?	☐Yes	☐No	☐Socially	☐ Occasionally	☐ Moderately	

WOMEN'S HEALTH ☐N/A

Pregnancies: ________ Live births: ________ Miscarriages: _______ Abortions: ________

Date of Last Menstrual Period: __________________ Are you pregnant? ☐**Yes** ☐**No**

Date of Last Mammogram:__________________ Results: ______________________________________

Current Bra Size: _________ Breast Cancer ☐**Yes** ☐**No** History of Breast Biopsy ☐**Yes** ☐**No**

REVIEW OF SYSTEMS **Please circle the following symptoms you have had recently:** ☐**No Symptoms**

General:	Fatigue. Fever. Chills. Sweats. Sleep disturbance. Recent weight gain or loss.
Eyes, Ears, Nose, & Throat:	Blindness. Blurred vision. Cataracts. Contact lenses. Double vision. Dry eyes. Eye irritation. Eye pain. Excessive tearing. Red eyes. Sensitivity to light. Visual changes. Ear discharge. Difficulty breathing through nose. Dizziness. Hearing loss. Ringing in the ears. Chronic nasal congestion. Nose bleeds. Loss of sense of smell. Past nasal injury. Sinus problems. Ulcer/sore. Capped teeth. Loose teeth. Tooth pain. Dental problems. Dentures. Difficulty swallowing. Hoarseness. Snoring.
Cardiovascular:	Chest pain. Congestive heart failure. Irregular / rapid heartbeat. Heart attack. Low blood pressure. Mitral valve prolapse/ need for antibiotics for dental procedures. Foot swelling. Palpitations/ Skipped beats. Poor circulation. Rheumatic fever. Varicose veins.
Respiratory:	Bronchitis. Bloody cough. Shortness of breath. Pneumonia. Recent cough. Wheezing. Tuberculosis.
Gastrointestinal:	Bloating. Blood in vomit / stools. Changes in appetite. Change in bowel habits. Chron's colitis. Constipation. Diarrhea. Hemorrhoids/ rectal bleeds. Gastritis/ reflux. Hepatitis/ jaundice. Irritable bowel syndrome. Nausea/ vomiting. Peptic ulcers. Ulcerative colitis.
Genitourinary:	Urinary infections. Urinating: Blood/ Difficulty/ Frequent/ Pain/ incontinent. STD. Yeast infections.
Musculoskeletal:	Arthritis. Difficulty walking. Extremity pain. Injuries. Joint pain. Leg cramps. Lupus Erythematosus, Rheumatoid arthritis. Unusual muscle weakness. Swelling.
Neurologic:	Dizziness/ fainting. Numbness. Migraines/ headaches. Seizures/ epilepsy. Sensory loss. Stroke. Weakness/ loss of balance.
Psychiatric:	Alcoholism. Anxiety. Depression. Drug abuse. Financial trouble. Marital problems. Schizophrenia.
Heme/ Immunologic:	Bleeding gums. Blood clot/ clotting disorder. Blood transfusion. Easy bruising. HIV complications. MRSA / VRE infections. Sickle Cell Anemia. Swollen lymph nodes.
Endocrine/ Hormonal:	Adrenal disorders. Labile blood glucose levels. Neuropathy. Steroid use. Thyroid symptoms.
Skin Disease:	Acne. Burn injury. Difficulty healing wounds. Excessive or unsatisfactory scarring. Itching/ Hives. Moles changing in appearance. Skin Cancer. Unexplained rash/ inflammation.
Breasts:	Abnormal Mammogram. Bloody discharge. Benign lump/ tumor. Cancer. Clear discharge. Milky discharge. Fibrocystic breasts. Pain. Reduction. Saline breast implants. Silicone breast implants.

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

X____
Signature of Patient, Parent, Guardian or Personal Representative Date Time

____
Name of Patient, Parent, Guardian or Personal Representative Date Time

____
Reviewed by (Clinic Personnel, if applicable) Date Time

____
Reviewed by (PreOp Personnel) Date Time

American Institute for Plastic Surgery/Surgery Center of Texas

Financial Responsibility

WORKERS COMP:

Date of Accident: _____/_____/_______Supervisor's Name / Phone #:________________/_________________

Employer's Name / Address:

_________________________/____

I give permission for my information regarding my medical condition to be released to my employer, insurance carrier, case manager and any medical personnel as needed. This will include all tests, reports, appointment information, billing information, forms and correspondence. PLEASE INITIAL: ______________

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and instruct my insurance carrier to make payment directly to American Institute for Plastic Surgery (AIPS) and/or Surgery Center of Texas for charges incurred. I further assign all rights to payment due for medical and/or surgical services under listed policies to AIPS Surgery Center of Texas, Anesthesia, Pathology and Radiology providers. I understand that any payment made on my behalf is not refundable to me. **PLEASE INITIAL: ______________**

FINANCIAL RESPONSIBILITY: I understand that AIPS/Surgery Center of Texas/Anesthesia/Pathology and Radiology providers as a courtesy will file with my insurance carrier. I understand that all co-pays and deductibles are due when services are rendered. I further understand that although these providers will file with my insurance, I am ultimately responsible for all charges incurred. **PLEASE INITIAL: ______________**

RELEASE OF PHOTOGRAPHIC IMAGES: I hereby grant permission for the use of any illustrations, photographs, or imaging records, created in my case, for use in scientific and professional journals, the AIPS website, or other medical or patient education material and presentations at any time during or after treatment, with complete confidentiality of my identity. **PLEASE INITIAL: ______________**

INFORMED CONSENT-PATIENT COMPUTER IMAGING: In the course of consultation, I may have been shown brochures or photographs of actual patients on a computer screen. I understand that those pictures and any alterations of these pictures are solely for the purpose of illustration. Furthermore, I understand that the outcome of any type of surgical procedure is related to my individual characteristics and health. I understand that because of the differences in how living tissues react to surgery, there may be no relationship between the electronic images created and my actual final surgical result. Use of computer imaging system offers an opportunity for me to discuss my desires and allows for improved communication with the medical staff. **PLEASE INITIAL: __________**

CONSENT/RESTRICTION OF THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS: I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans of future care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the healthcare professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, a means by which a third party payer can verify that services billed were actually provided, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals. I wish to have the following restrictions or disclosure of my health information. ☐ None ☐ Other ____

____

SIGNATURE OF PATIENT or GUARDIAN:

____

Patient, if minor (Parent or guardian signature) **Date** **Time**

Surgery Center of Texas

HIPAA and YOUR PRIVACY RIGHTS

We strongly believe in doing everything we possibly can to safe-guard the privacy and security of your health information and records. As a result, we have made some changes in our office management procedures to make sure we follow the Health information Portability and Accountability Act (HIPAA). Passed into law in 1996, HIPAA sets federal standards for the privacy and security of patient information for all healthcare providers, plans, insurance companies and anyone they do business with.

HIPAA gives you additional rights regarding control and use of your health information, meaning you have more access and control than ever. Please take a few minutes to review these new rights. We're happy to answer any questions you may have.

Control Over Your Health Information

• All healthcare providers (and health plans) are now required to give you a written explanation of how they use and disclose your personal information before they can treat you. This way, you can decide if a provider is doing everything they should to protect your privacy before you choose them as your caregiver.
• We must, by law, post a Notice of Privacy Practices, which outlines how we secure the privacy of patient information, in a place where you can easily see it.
• We must get your signature for non-routine uses and disclosures of your information. A non-routine use is any situation not directly related to treatment, payment or operations. For example, if your child is going to summer camp and the camp needs a medical history, you will be asked to authorize us to release it before we can send the information. You have the right to say no, and you don't have to tell anyone why.
• Authorizations of non-routine information are one-time-only, case by case, for the use defined by you.

Access to Your Health Information

•You can get copies of your medical records simply by asking for them. Healthcare providers are required to get you a copy of your records within 15 days of your request. There may be a cost for this service.
• Providers also must give you a history of non-routine disclosures if you ask for it. All you need to do is ask for the record and it is provided to you – no justification is needed.
•You may also amend your medical records. You cannot change the existing record, but you can add noted or comment on any procedures, treatments, payments or operations.
• The provider then has the right to respond to your amendment. This way, you can be sure your records reflect your side of the story about treatment and payment issues.

Patient Recourse If Privacy Protections Are Violated

• Every healthcare provider must also inform you of grievance procedures. If your privacy os violated, report the incident to our Privacy Officer immediately. You also have the right to report any violation to the Department of Health and Human Services. Office of Civil Rights, 200 Independence Ave, S.W., Washington, D.C. 20201.
•If you decide to file a grievance either with us or with the Department of Health and Human Services, we are not allowed to discriminate or retaliate against you in any way.
• Aside from these new rights to access and control of your medical information under HIPAA, there are also clear limits on all healthcare providers regarding how they disclose medical information.
•Here are some of the key aspects of these boundaries:

- **Providers must ensure that health information is not used for non-heath purposes**. Health information (covered by the privacy rules) generally may not be used for purposes not related to health care – such as disclosures to employers to make personnel decisions, or to financial institutions – without your explicit authorization.
- **There are clear, strong protections against using health information for marketing.** The privacy rules set new definitions, restrictions and limits on the use of patient information for certain marketing purposes. Providers must get your specific authorization before sending you any materials other than those related to treatment.
- **Use only the minimum amount of information necessary**. In general, uses or disclosures of information will be limited to the minimum necessary. This does not apply to disclosure of records for treatment purposes, because physicians, specialists and other providers may need access to the full record to provide quality care.

Exceptions

There are situations where healthcare providers may not have to follow these privacy rules. They include: emergency circumstances; identification of a body or the cause of death; public health needs; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security.

We understand your right to have your medical information kept confidential. Our compliance with the Health Information Portability and Accountability Act is one example of our advocacy and leadership on issues of patient's rights and privacy of information. We encourage you to ask questions and look forward to working together to improve the quality of your healthcare experience.