PORT CITY PLASTIC SURGERY
BRIAN G. WIDENHOUSE M.D.

Welcome

Please complete the following information below.

Today's Date: _____ **Patient Name:** _____

Patient Social Security Number: _____

Patient Date of Birth: _____ Age: _____ ○ Female ○ Male Marital Status: _____

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

Home Phone Number: _____ Cell Phone Number: _____

Email Address: _____

Parent/Guardian (if under age 18): _____

Guardian's Social Security Number: _____

Employer: _____

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

Phone Number: _____

Spouse: _____ Date of Birth (even if deceased): _____

Spouse's Social Security Number (even if deceased): _____

Spouse's Employer: _____

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

Employer Phone Number: _____

Next of Kin (not living with patient): _____

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

Phone Number: _____ Relationship to Patient: _____

Insurance Information

Primary: _____ Secondary: _____

Policy Holder Name (if different from above): _____

Policy Holder Social Security Number: _____ Policy Holder Date of Birth: _____

How did you hear about us? (If referred by another physician, please give name): _____

Reason for visit: _____

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Office & Financial Policy

Please read and sign below.

Initial Visit/Subsequent Visits: We request payment at the time services are rendered. Payment can be made with cash, check, Visa, MasterCard, Discover or Amex. If we are a participating provider for your insurance company, we will request the appropriate deductible and co-payment at the time services are rendered. Please be prepared to pay your portion. You are responsible for the account and services provided.

Collections: Monthly statements are mailed for accounts with unpaid balances. All delinquent accounts may be turned over to a collection agency. In the event your account is sent to collection, a 22% service fee will be added. There is a $50 charge for all returned checks.

Appointments: Please give our office as much notice as possible if you will be unable to keep your scheduled appointment, or if you would like to reschedule your current appointment. Failure to show up for a consultation or cancellation of a consultation within 24 hours of the scheduled time will result in a $50 charge.

Surgery (covered by your insurance): You will be responsible for your co-payment, deductible, and co-insurance. Payment can be made with cash, check, Visa, MasterCard, Discover or Amex and is due two weeks prior to your procedure. You must confirm your surgery two weeks prior to your date of surgery and attend your pre-op appointment. Otherwise, your procedure may be canceled.

Cosmetic and Skin Care Procedures: Payment, in full, is due two weeks prior to your scheduled procedure. All fees paid for cosmetic procedures, skin care procedures, and skin care products are nonrefundable. Payment can be made with cash, check, Visa, MasterCard, Discover, or Amex. You must confirm your procedure two weeks prior to your date of surgery, make payment in full, and attend your pre-op appointment. Otherwise, your procedure may be canceled.

Please notify staff of any changes to your address, phone number, or insurance coverage. We are always available to answer any questions that you may have concerning our policies. We encourage open communication between patients and our office to avoid any misunderstandings.

Assignment and Release: I hereby authorize my insurance company to pay benefits directly to the physician. I also authorize Port City Plastic Surgery to release any information required to process all claims. I am financially responsible for all non-covered services. By signing this form, I am authorizing a consultation with the physician.

Signature: _____ **Date:** _____

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Patient History

Please complete the following information below.

Please list previous surgeries, including the type of procedure and year performed:

_____

_____

Indicate the type(s) of anesthesia received in the past. List any complications/reactions you experienced:

Local Anesthesia - Complications/Reactions ❍ **Yes** ❍ **No** If **yes**, Please explain.

_____

_____

IV Sedation - Complications/Reactions ❍ **Yes** ❍ **No** If **yes**, Please explain.

_____

_____

General Anesthesia - Complications/Reactions ❍ **Yes** ❍ **No** If **yes**, Please explain.

_____

_____

Personal Past History. Have you ever experienced:

Abnormal Bleedlng: ❍ Yes ❍ No
Acid Regurgitation: ❍ Yes ❍ No
Angina: ❍ Yes ❍ No
Diabetes: ❍ Yes ❍ No
Heart Attack: ❍ Yes ❍ No
Hypertension: ❍ Yes ❍ No
Snoring: ❍ Yes ❍ No
Abnormal Clotting: ❍ Yes ❍ No
Anemia: ❍ Yes ❍ No
Asthma: ❍ Yes ❍ No
Fainting Spells: ❍ Yes ❍ No
Hepatitis: ❍ Yes ❍ No
Sleep Apnea: ❍ Yes ❍ No
Weight change in the past 12 months: ❍ Yes ❍ No

Please describe if you checked **yes** on the list to the left.

Other serious Illnesses?

_____

_____

_____

_____

_____

Habits:

Smoke: ❍ Yes ❍ No Amount: _____
Alcohol: ❍ Yes ❍ No Amount: _____
Coffee/Tea/Cola: ❍ Yes ❍ No Amount: _____
Daily Exercise: ❍ Yes ❍ No Amount: _____

Primary Care Physician: _____

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

Phone Number: _____ Date last seen by Primary Care Physician: _____

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Patient Medications & Allergies

Please read and answer below.

Name: _____ Date of Birth: _____

Medications

Prescription Drugs:

Dose or Number of Pills Per Day:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Non-Prescription Drugs
(vitamins, herbs, supplements):

Dose or Number of Pills Per Day:

_____ _____

_____ _____

_____ _____

_____ _____

Regular Aspirin Use: ❍ Yes ❍ No Dosage & Frequency: _____

NSAIDs (Advil, Motrln, Ibuprofen): ❍ Yes ❍ No Dosage & Frequency: _____

Drug Allergy: ❍ Yes ❍ No

List drug(s) and type of reaction:

_____

_____

_____

_____

_____

Latex Allergy: ❍ Yes ❍ No

Tape Allergy: ❍ Yes ❍ No

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Patient Release Information

Please read and sign below.

I, _____ , do hereby authorize a representative from Port City Plcstlc Surgery to speak with the following person(s) regarding my (please check all that apply),

Name & Relationship	Phone Number	Medical Care	Financial	Appointments
_____	_____	○	○	○
_____	_____	○	○	○
_____	_____	○	○	○

Signature: _____ **Date:** _____

I do **(NOT)** wish for any medical lnformatlon/appoinments to be released to any representative on my behalf.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

This form will be valid until patient rescinds authorization In writing.

Notice of Privacy Practices **Please read and sign the next page.**

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations.

For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations Include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

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Notice of Privacy Practices

Please read and sign below.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health Information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders such as voice mall messages, postcards, or letters.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your Information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health Information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read a copy of Port City Plastlc Surgery's Notice of Privacy Practices. I understand I will be provided a copy upon my request.

_____ _____

Date Signature of Patient or Patient's Representative

_____

Description of Representative's Authority