BERLET PLASTIC SURGERY

Dr./Mr./Mrs./Miss/Ms._____
First Name Middle Last Name Nickname (if used)

☐ **Male** ☐ **Female** **STATUS:** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widow**

How would you like to be addressed? Circle one: Mr. Mrs. Miss. Ms. Other: _____

_____
Street Address

_____ _____ _____
City **State** **Zip Code**

(____)_____ (____)_____ (____)_____
Home Telephone Number **Business Telephone Number** **Cellular Telephone Number**

_____/_____/_____ ____/____/____ _____ _____
Social Security Number **Date of Birth** **Age** **E-mail Address**

_____
Employed By **Street Address** **City/State** **Zip Code**

_____
Emergency Contact **Phone** **Relationship**

☐ **Motor Vehicle Accident** ☐ **Worker's Compensation** ☐ **Other _____**

_____ _____ _____ _____
Subscriber of Policy **Relationship** **Date of Birth** **Social Security Number**

REASON FOR VISIT: _____ REFERRED BY: _____

****PLEASE PRESENT ALL INSURANCE CARDS TO RECEPTIONIST****
IF YOU HAVE A SECONDARY INSURANCE PLEASE ADVISE US

I understand that a fee is charged for all first visits, examinations, cosmetic evaluations and medical reports. Fees for cosmetic surgery are payable in advance.

ACKNOWLEDGEMENT: I hereby acknowledge that in consideration for treatment rendered to me and/or my child or child in my care that I am responsible and will pay for all charges and fees for services rendered by the doctor. I understand that although I may have insurance to cover the cost of treatment, I remain responsible for payment. All payments are due within thirty (30) days of receipt of the bill. Any account that is forwarded to Collections will incur a 35% surcharge. I understand that if I bounce a check and/or use a credit card deceitfully, I will be responsible for the fee charged to Dr. Berlet.

_____
Signature (Patient or Responsible Party) **Date**

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS: I hereby authorize the doctor to release any information acquired in the course of my examination or treatment and further authorize payment of the surgical and/or medical benefits directly to the physician.

_____
Signature (Patient or Responsible Party) **Date**

AUTHORIZATION TO PHOTOGRAPH: I hereby grant authority to the doctor to take any photographs of the patient whose name appears above which may be necessary. I also grant authority to the doctor to use the said photographs for any scientific presentations or publications.

_____
Signature (Patient or Responsible Party) **Date**

Non-Par Acknowledgement: Berlet Plastic Surgery has advised me that they do not participate with any insurance carrier. I am responsible for any charges incurred and will be balanced billed for all co-payments, deductibles, and non-covered charges over Usual and customary.

_____
Signature (Patient or Responsible Party) **Date**

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Height: _____ **Weight:** _____ **Date:**_____

PAST MEDICAL HISTORY:

Have you ever had a REACTION to a GENERAL anesthetic?	Yes	No
Have you ever had a REACTION to a LOCAL anesthetic?	Yes	No
Do you have high blood pressure?	Yes	No
Do you form heavy scars?	Yes	No
Do you have frequent infections or boils?	Yes	No
Have you ever had any excessive bleeding problems?	Yes	No
Have you ever had any significant emotional problems?	Yes	No
Have you ever been advised or had psychiatric care?	Yes	No
Have you seen other plastic surgeons about the SAME problem which brings you here?	Yes	No

LIST OTHER MEDICAL CONDITIONS:

_____

_____

HAVE YOU EVER BEEN HOSPITALIZED FOR A MEDICAL CONDITION?:

_____

_____

PAST SURGERIES (*List Medical Problem, date, doctor*):

_____

_____

MEDICATION: *(List prescribing doctor and reason for treatment) include hormone replacement, recreational drugs, & diet pills; also all vitamins, over-the-counter, i.e. aspirin, herbs, tea or alternative therapies:*

_____

_____

DRUG ALLERGIES: PLEASE Circle: YES or NO

If you answered yes, please list medications and reactions:

_____

SOCIAL HISTORY:
Cigarettes: _____

Have you been exposed to heavy second hand cigarette, cigar or pipe smoke for an extended period of time on a regular basis in the past two years?

_____

Have you ever smoked? If yes, for how long and when did you quit? _____.

Alcohol: _____

FAMILY HISTORY: (***List any medical problems & relationship)***

_____

Primary Care Physician _____ **Phone** _____

Pharmacy Name _____ **Phone** _____

_____

SIGNATURE **Date** **Relationship to Patient (Self, Mother,etc.)**

BERLET PLASTIC SURGERY

Acknowledgement of Receipt of Notice of Privacy Practices

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of the Berlet Plastic Surgery's Notice of Privacy Policies on the date indicated below.

Signature:_____ Date: _____

Patient: _____

Information about Agent (attach appropriate documentation):

Agent: _____

Title: _____