# *Port City Plastic Surgery*

Please complete the following information

Today's Date: _____

Patient's Name: _____
Patient's Social Security Number: _____ Patient's Date of Birth: _____
Age: _____ Sex: _____ Marital Status: _____

Parent/Guardian (If under age 18): _____
Guardian's Social Security Number: _____

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

Home Phone Number: _____ Cell Number: _____

E-mail Address: _____

Employer: _____
Address: _____
Phone Number: _____

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

Spouse's Employer: _____
Employer Address: _____
Employer Phone Number: _____

Next of Kin (Not living with patient): _____
Address: _____
Phone Number: _____ Relationship to Patient: _____

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

_____

Reason for visit: _____

## *Insurance Information*

Primary: _____ Secondary: _____
Policy Holder (If different from above): _____
Social Security Number: _____ DOB: _____

# ***Office and Financial Policy***

**Initial Visit/Subsequent Visits:** We request payment at the time services are rendered. Payment can be made with cash, check, Visa, Mastercard, or Discover. 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. After two statements are sent, you will receive a letter informing you of your past due account. All delinquent accounts, which are not paid within a reasonable amount of time, will be turned over to our collection agency. In the event your account is sent to collection, a 22% service fee will be added. There is a $30 charge for all returned checks.

**Appointments:** Please give our office as much notice as possible if you will be unable to keep your appointment or if you would like to reschedule your current appointment.

**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, or Discover. You must confirm your surgery two weeks prior to your date of surgery. If we do not receive confirmation, your procedure will be cancelled.

**Cosmetic Procedures:** Payment, in full, is due two weeks prior to your scheduled procedure. Payment can be made with cash, check, Visa, Mastercard, or Discover. You must confirm your surgery two weeks prior to your date of surgery. If we do not receive confirmation, your procedure will be cancelled.

*Please notify our 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.

Signed: _____ Date: _____

Name: _____ DOB: _____

**Medications:** List dose or number of pills per day.

**Prescription Drugs:**

_____

_____

_____

_____

_____

_____

**Non-Prescription Drugs** (Vitamins, Herbs, Supplements):

_____

_____

_____

Regular Aspirin Use: Y _____ N _____ Dosage & Frequency: _____

NSA (Advil, Motrin, Ibuprofen): Y _____ N _____ Dosage & Frequency: _____

**Drug Allergy:** Y _____ N _____ List drug(s) and type of reaction:

_____

_____

_____

**Latex Allergy:** Y _____ N _____ **Tape Allergy:** Y _____ N _____

**Personal Past History-** Have you ever experience:

- Abnormal Bleeding: Y _____ N_____
- Acid Regurgitation: Y _____ N_____
- Angina: Y _____ N_____
- Diabetes: Y_____ N_____
- Heart Attack: Y_____ N_____
- Hypertension: Y_____ N_____
- Snoring: Y_____ N_____
- Abnormal Clotting: Y _____ N_____
- Anemia: Y_____ N_____
- Asthma: Y _____ N_____
- Fainting Spell: Y _____ N_____
- Hepatitis: Y _____ N_____
- Sleep Apnea: Y _____ N_____

Weight change in the past 12 months: Y _____ N _____

Other serious illnesses: Y _____ N _____

Please describe questions with a "yes" answer:

_____

_____

_____

_____

_____

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):

_____

_____

**General Anesthesia:** (Complications/Reactions):

_____

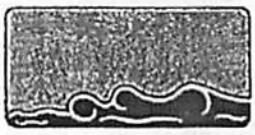
_____

**Habits:**

Smoke: Y _____ N _____ Amount: _____
Alcohol: Y _____ N _____ Amount: _____
Coffee/Tea/Cola: Y _____ N _____ Amount: _____
Daily Exercise: Y _____ N _____ Amount: _____

Primary Care Physician: _____
Address: _____
Telephone: _____

Date last seen by Primary Care Physician: _____



port city
plastic
surgery

BRIAN G. WIDENHOUSE M.D.

## *Personal Release of Information*

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

| Name: | Relationship: | Phone Number: | Medical Care | Financial | Appointments (check) | |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

_____ _____

(Signature of patient) (Date)

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

_____ _____

(Signature of patient) (Date)

_____ _____

(Witness) (Date)

***This form will be valid until patient rescinds authorization in writing.***

2683 Lake Park Drive - Charleston, SC 29406 - 843.518.5000 (phone) - 843.614.8959 (fax) - www.portcityplasticsurgery.com

***ACKNOWLEDGEMENT OF***
***RECEIPT OF***
***NOTICE OF PRIVACY PRACTICES***

I, _____, hereby acknowledge that I received a hard copy/e-mail of ***PORT CITY PLASTIC SURGERY's*** Notice of Privacy Practices.

_____ _____

(Date) (Signature of Patient or Patient's Representative)

_____

(Description of Representative's Authority)

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