Patient Information

Date: _____ Referred By:_____

Patient's Name:_____ Date of Birth:_____ Age:_____

Marital Status: ○S ○M ○W ○D ○Sep. Sex: ○M ○F Height:_____ Weight:_____ Ideal Weight:_____

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

Home Telephone:_____ Cell #:_____ Work Telephone:_____

Patient's Employer:_____ City:_____ State:_____ Zip:_____

Email Address:_____ Preferred method of contact: _____ Text: ○Y ○N

Spouse's/Parent's Name:_____ SS#:_____ Date of Birth:_____

Spouse's Telephone:_____ Cell#:_____ Work Telephone:_____

Spouse's/Parent's Employer:_____ Occupation:_____

Employer's Address:_____ City:_____ State:_____ Zip:_____

Responsible Party Information

Name of Responsible Party:_____ SS#:_____ Date of Birth:_____

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

Telephone:_____ Cell #:_____ Work #:_____

Responsible Party's Employer:_____ Occupation:_____

Employer's Address:_____ City:_____ State:_____ Zip:_____

Relationship to Patient:_____

Insurance Information

Name of Insurance Co.:_____ Contract #:_____ Group No.:_____

Name of Insured as it Appears on Card:_____ Date of Birth:_____ SS#:_____

Name of Secondary Insurance Co.:_____ Contract #:_____ Group #_____

Name of Insured as it Appears on Card:_____ Date of Birth:_____ SS#:_____

Were You Injured in a Motor Vehicle Accident? ○Yes ○No Date of Accident:_____ State of Accident:_____

In Case of Emergency Notify (other than Responsible Party)

Name:_____ Phone:_____ Relationship:_____

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

Explanation of Payment Policy and Insurance Filing Procedures

I hereby authorize Grotting & Cohn Plastic Surgery to release any and all information acquired in my examination and treatment to my insurer listed above. If I am covered by Blue Cross, Medicare, and/or Medicaid I will furnish my insurance card and signature. If I am covered by other insurance, I will furnish the necessary forms to this office.

I hereby assign and authorize payment directly to the above named clinic. Any medical and surgical benefits otherwise payable to me, should an insurance payment be received that is less than the physician's usual charge for the services provided, I will be responsible for the difference.

I also agree to pay all cost of collection including, but not limited to reasonable attorney's fees, and waiver all claims of exemption under the law of the state of Alabama.

I authorize treatment by Grotting & Cohn Plastic Surgery and personnel.
****Form must be signed and dated by patient or responsible party.**

Date:_____ Signature:_____

Name:_____ Date:_____

What Procedure are you interested in?

_____

HABITS

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

Medications (list dose or number of pills per day)

Prescription Drugs	Non-Prescription (Vitamins; Herbs)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Regular Aspirin Use: ○Y ○N Dosage & Frequency: _____
NSA (Advil, Motrin, Ibuprofen): ○Y ○N Dosage & Frequency: _____
***Drug Allergy:** ○Y ○N List Drug(s) & type of reaction:

_____

_____

Latex Allergy: ○Y ○N Tape Allergy: ○Y ○N

Family History

Have any blood relatives ever had any of the following

Abnormal Bleeding:	○Y	○N	Coronary Surgery:	○Y	○N	Kidney Disease:	○Y	○N
Abnormal Clotting:	○Y	○N	Diabetes:	○Y	○N	Tuberculosis:	○Y	○N
Anesthetic Problems:	○Y	○N	Heart Attack:	○Y	○N	Other Illness:	○Y	○N
Cancer:	○Y	○N	Hypertension:	○Y	○N			

Please describe questions with “Yes” answer:

_____

_____

Personal History

Have you ever had any of the following?

Abnormal Bleeding:	○Y	○N	Asthma:	○Y	○N	Hypertension:	○Y	○N
Abnormal Clotting:	○Y	○N	Diabetes:	○Y	○N	Sleep Apnea:	○Y	○N
Acid Regurgitation:	○Y	○N	Fainting Spell:	○Y	○N	Snoring:	○Y	○N
Anemia:	○Y	○N	Heart Attack:	○Y	○N	Hepatitis:	○Y	○N
Angina:	○Y	○N	Weight Change (12 mo):	○Y	○N	Other Illness:	○Y	○N

Please describe questions with “Yes” answer:

_____

_____

Have you ever received a Transfusion? ○Y ○N If Yes, explain: _____

Have you ever been tested for HIV? ○Y ○N If Yes, What year_____ Results: ○Pos ○Neg

Do you wear any of the following:

Contact Lenses: ○Y ○N Eye Glasses: ○Y ○N Hearing Aid: ○Y ○N Dentures: ○Y ○N

Previous Surgery: Type of Procedure & Year:

_____

_____

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

Local Anesthesia: Complication/Reaction:

_____

General Anesthesia: Complication/Reaction:

_____

Spinal/Epidural: Complication/Reaction:

_____

Primary Care Physician (Name):_____ (Phone):_____ Date Last Seen:_____

For Women Only:

Number of Pregnancies: _____ Number of Children: _____ Breast Feed? _____ How Long? _____ Last Period: _____

Date of Last Mammogram: _____ Results: _____ Current Bra Size: _____

Authorization for Disclosure of Information

I authorize Grotting & Cohn Plastic Surgery to disclose complete information concerning his medical findings and treatment of the undersigned, from the initial office visit until the date of the conclusion of such treatment to those individuals who, in Grotting & Cohn Plastic Surgery's sole determination, are required to receive such information *for the purpose of medical treatment, medical quality assurance and peer review.*

Patient Signature: _____ Date: _____

GROTTING & COHN PLASTIC SURGERY

James C. Grotting, MD **Al B. Cohn, MD**

CONSENT FORM

Please initial each line and sign at the bottom of the page and return to the front desk. Thank You.

_____ I consent to necessary treatment of diagnostic tests/ procedures including drug, medicines, performance of operations and conduct of studies that may be conducted by Dr. Grotting, Dr. Cohn and/or their staff.

_____ I understand that if **I am uninsured or have an insurance that is not accepted** at the practice, that I will be responsible for payment IN FULL at time of service.

_____ I understand that **insurance co pays, deductibles, co-insurance and charges not filed with insurance are due at time of service**. Failure to make payment when requested is a basis for legal action, and the undersigned agrees to pay all cost for collections, including a reasonable fee, and herby waives his/her rights of exemption under the laws of the State of Alabama and any other state.

_____ I understand that **it is my responsibility to know if my insurance requires a referral for any office visit and/or office procedure. It is my responsibility to confirm one is obtained.** I understand medical services may not be rendered without the proper referral on file. If I do not obtain a referral, I am responsible for any charges made to my account.

_____ I understand that **I will be responsible for ANY charges that are not paid by my insurance company**. Not all services are covered, and I understand that it is MY RESPONSIBILITY to know the limits of my coverage and to pay any fees that my insurance company denies.

_____ I understand that **most office procedures may fall under major medical. I will be responsible for paying the deductable and/or coinsurance at the time of service**.

_____ I am aware that the practice has a **Notice of Privacy Practices** that contains a section on Patient Rights. I have been given the opportunity to review this Notice (Effective Date 9/23/13).

_____ I am aware that most standard email does not provide a secure means of communication. There is some risk that any protected health information contained in email may be disclosed to, or intercepted by, unauthorized third parties. Use of more secure communications, such as phone or fax is an always an alternative that is available to you.

_____ I am aware that I may request restrictions concerning the use of my personal medical information and that my request may not be able to be fulfilled and I will be notified if my request is denied.

_____ Person(s): we may speak with regarding your healthcare: (please list name, relationship, and contact number)

_____

_____

_____

_____ I request restrictions concerning my personal medical information:

_____

_____

_____

Patient Signature _____ **Date** _____