MEDICAL /HISTORY REGISTRATION FORM

PLEASE PRINT

Date: _____ Sex M☐ F☐

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
DOB: _____ SS#: _____
Home Ph: _____ Cell: _____

Are you employed? ☐Yes ☐No ☐Self Employed ☐Retired

Name of Employer: _____
Type of Occupation: _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Spouse Name: _____

In Case of Emergency, Contact:

Name: _____
Home Ph: _____
Cell: _____ Work: _____
Relationship to Patient? _____
How Did you hear about us? _____

Insurance Information
(If this is cosmetic, please disregard this section)

Primary: _____
Member ID: _____ Gp: _____
Ph: _____
Name of Insured: _____
Relationship to Patient: _____
DOB: _____ SSN: _____

Secondary: _____
Member ID: _____ Gp: _____
Ph: _____
Name of Insured: _____
DOB: _____ SSN: _____

Tertiary: _____
Policy: _____ Gp: _____
Ph: _____
Name of Insured: _____
DOB: _____ SSN: _____

Who is Responsible for this account?

_____
Signature

Insurance Assignment And Release

I certify that I have insurance coverage with _____ and assign direct payment to **Nirvana Plastic Surgery, PA** for insurance benefits on services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named practice may use of my health care information and may disclose such information to the above-named insurance company(ies) and the agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

Medicare Authorization
I request that payment of authorized Medicare benefits and, if applicable Medigap benefits, be made on my behalf to **Nirvana Plastic Surgery, PA** for service furnished to me by that provider.

_____ _____
Signature of Patient, Parent or Guardian **Date**

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PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY:

Cardiovascular

- ☐ A-fib
- ☐ Anemia
- ☐ Aneurysm
- ☐ Bleeding Disorder
- ☐ Carotid Artery Disease
- ☐ Edema
- ☐ Endocarditis
- ☐ Heart Disease
- ☐ High ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperlipidemia
- ☐ Irregular Heart Rate
- ☐ Mitral Valve Prolapse
- ☐ Myocardial Infarct/Heart Attack
- ☐ Pace Maker
- ☐ Peripheral Vascular Disease
- ☐ Polycythemia Vera
- ☐ Syncope and Collapse
- ☐ Tachycardia

Connective Tissue/Auto Immune

- ☐ Auto Immune Disease
- ☐ Connective Tissue Disease
- ☐ Lupus
- ☐ Polychondritis
- ☐ Raynaud's Disease
- ☐ Rheumatic fever
- ☐ Rheumatoid Arthritis
- ☐ Sarcoidosis
- ☐ Sjögren's Syndrome

Digestive/Gastrointestinal

- ☐ Appendicitis
- ☐ Bloating/Constipation
- ☐ C-Diff
- ☐ Colon Cancer
- ☐ Crohn's Disease
- ☐ Diverticulosis
- ☐ Gall Bladder Disease
- ☐ Gallstones
- ☐ Gastritis
- ☐ Gastrointestinal Bleeding
- ☐ GERD
- ☐ Hiatal Hernia
- ☐ IBS
- ☐ Intestinal Disease
- ☐ Liver Disease
- ☐ Stomach Ulcers
- ☐ Ulcerative Colitis

Endocrine

- ☐ Diabetes
- ☐ Hyperglycemia
- ☐ Hyperthyroid
- ☐ Hypothyroidism
- ☐ PCOS
- ☐ Thyroid Mass
- ☐ Thyroid Problems

Eyes,Ears,Nose, Throat

- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Hearing Loss
- ☐ Post Nasal Drip

Genitourinary

- ☐ BPH
- ☐ Dialysis
- ☐ Endometrial Cancer
- ☐ Hormone Replacement Therapy
- ☐ Kidney Disease
- ☐ Prostate Problem
- ☐ STD/Veneral Disease
- ☐ Urinary Retention

Infections

- ☐ Chicken Pox
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ Herpes/Cold Sores
- ☐ HIV
- ☐ MRSA
- ☐ Mumps
- ☐ Polio
- ☐ Sepsis
- ☐ Shingles
- ☐ Typhoid Fever

Lymphatic

- ☐ Lymphoma

Musculoskeletal

- ☐ Arthritis
- ☐ Back Pain
- ☐ Degenerative Disc Disease
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Herniated Disc
- ☐ Neck ☐ Shoulder Pain

Musculoskeletal (continued)

- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Restless Legs Syndrome

Neurological

- ☐ ADHD
- ☐ Alzheimer's Disease/Dementia
- ☐ Anxiety
- ☐ Bell's Palsy
- ☐ Bipolar Disorder
- ☐ Brain Tumor
- ☐ Chemical Dependency
- ☐ Chronic Pain Syndrome
- ☐ Depression
- ☐ Dysthymia
- ☐ Epilepsy
- ☐ Erb's Palsy
- ☐ Hemiparesis/Paralysis
- ☐ Headaches
- ☐ Hydrocephaly
- ☐ Migraine
- ☐ Neuropathy
- ☐ RSD/Pain Disorder
- ☐ Sciatica
- ☐ Seizures
- ☐ Spina Bifida
- ☐ Tremors
- ☐ Visual Hallucinations

Respiratory

- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Lung Cancer
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Pneumonia
- ☐ PTSD
- ☐ Seasonal Allergies
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Tracheomalacia
- ☐ Tuberculosis

Skin/Breast

- ☐ Acne
- ☐ Benign Breast Cyst/Mass
- ☐ Breast Cancer
- ☐ Breast Mass
- ☐ Cystic Acne
- ☐ Keloids
- ☐ Non-healing wound
- ☐ Skin Cancer
- ☐ Other cancers:

_____

WOMEN ONLY:

- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast Augmentation
- ☐ Breast Lump
- ☐ Extreme menstrual pain
- ☐ Nipple discharge
- ☐ Other : _____

Are you pregnant?
☐ Yes ☐ No

Are you currently breastfeeding?
☐ Yes ☐ No

Prior pregnancies? _____

Did you breastfeed?
☐ Yes ☐ No

Date of last mammogram:

_____

Abnormal Mammogram Results:
☐ Yes ☐ No

Where was your Mammogram performed?

_____

Date of last menstrual period:

_____

Date of last Pap smear:

_____

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MEDICAL /HISTORY REGISTRATION FORM

PRIMARY CARE PHYSICIAN INFORMATION

Primary Physicians Name: _____ **Physicians Ph:** _____

Facility Name: _____ **Date of Last Exam:** _____

FAMILY HISTORY

Has anyone in the family experienced any of the following?

	RELATION		RELATION
Allergies	_____	Lung Cancer	_____
Alzheimer's/Dementia	_____	Lung Disease	_____
Aneurism	_____	Lymphoma	_____
Arthritis	_____	Mental Illness	_____
Asthma	_____	MRSA	_____
Auto Immune Disease	_____	Migraine Headaches	_____
Bleeding Disorders	_____	Ovarian Cancer	_____
Blood Clots	_____	Pneumonia	_____
Brain Tumor	_____	Prostate Cancer	_____
Breast Cancer	_____	Reaction to Anesthesia	_____
Cervical Cancer	_____	Renal Failure	_____
Colon Cancer	_____	Sepsis	_____
Congestive Heart Failure	_____	Seizures/epilepsy	_____
COPD	_____	Skin Cancer	_____
Diabetes	_____	Stroke	_____
Emphysema	_____	Thyroid Disease	_____
Fibromyalgia	_____	Tuberculosis	_____
Gastrointestinal Bleeding	_____	UHL Disease	_____
Gout	_____	Non-contributory	_____
Heart Disease	_____	Other:	_____
Leukemia	_____		
Liver Cancer	_____		

SOCIAL HISTORY

Check which ones you use and how much:

Alcohol Use: ☐ Greater than 1 daily ☐ Less than 1 Daily ☐ None
Caffeine: ☐ 1-2 Daily ☐ Greater than 2 daily ☐ None
Exercise: ☐ 3-5 times Weekly ☐ Daily ☐ Once Weekly ☐ None
Recreational Drug Use: ☐ No ☐ Yes: _____
Smoking Status: ☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker

NIRVANA PLASTIC SURGERY transcend time

MEDICAL /HISTORY REGISTRATION FORM

HOSPITALIZATION HISTORY

Have you ever been hospitalized? ☐ Yes ☐ No ☐ See List

(Please include date and facility)

_____

_____

_____

_____

SURGICAL HISTORY

Have you ever had surgery? ☐ Yes ☐ No ☐ See List

(Please include date and facility)

_____

_____

_____

HAVE YOU EVER EXPERIENCED ANY COMPLICATIONS WITH ANESTHESIA? ☐ Yes ☐ No

If yes, Please Explain: _____

MEDICATIONS/ALLERGIES

Pharmacy Name: _____ **Street, City:** _____ **Ph:** _____

List medications, vitamins or supplements you are currently taking: (or you may provide a list)

****Please include dosage****

_____

_____

_____

_____

_____

Are you allergic to any medications or substances?

Please list reaction

☐ No Known Medication Allergies ☐ No Non-Medication Allergies

_____ Reaction:_____ Severity: ☐ Mild ☐ Moderate ☐ Severe

_____ Reaction:_____ Severity: ☐ Mild ☐ Moderate ☐ Severe

_____ Reaction:_____ Severity: ☐ Mild ☐ Moderate ☐ Severe

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

_____ _____ _____

Signature of Patient, Parent or Guardian **Relationship to Patient:** **Date:**

MEDICAL /HISTORY REGISTRATION FORM

How May We Contact You?

(Please check all that apply)

What is your preferred method of communication?

☐**Home** ☐**Cell** ☐**Work** ☐**Email**

☐**Home Phone:** **(_____) _____**

- o May we leave a voicemail? ☐Yes ☐No
- o May we leave a message with another person? ☐Yes ☐No

☐ **Cell:** **(_____) _____**

- o May we leave a voicemail? ☐Yes ☐No
- o May we leave a message with another person? ☐Yes ☐No

Is it OK for us to text you:

- o An Appointment Reminder ☐Yes ☐No
- o Medical or Scheduling Info ☐Yes ☐No
- o Special Offers ☐Yes ☐No

Who is your cell phone provider?

☐AT&T ☐Sprint ☐T-Mobile ☐Verizon ☐Other: _____

☐ **Work Phone:** **(_____) _____**

☐ **Email:** **_____**

Is it OK for us to email you:

- o An Appointment Reminder ☐Yes ☐No
- o Medical or Scheduling Info ☐Yes ☐No
- o Special Offers ☐Yes ☐No

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MISSED APPOINTMENT/LATE CANCELLATION POLICY

We would like to thank you for choosing us your provider of medical and aesthetic services. In order to give you and all of our patients, the best possible care/service, we request that you review our policy regarding missed appointments and late cancellations. **A missed appointment is when you fail to show up for an allotted appointment time, without a phone call. A late cancellation is when you fail to give a notice of at least 24 hours prior to your scheduled appointment time.** Please remember that we have reserved appointment times to accommodate your schedule. Therefore, we respectfully request at a 24-hour notice in order to reschedule your appointment. This will enable us to offer your cancelled appointment time to other patients. If you are unable to keep your scheduled appointment time, please contact our office at (843)839-2004 at least 24-hours in advance in order to avoid a missed appointment/late cancellation fee. This charge is not covered by your insurance carrier. **If you fail to give us notice of your missed appointment or you cancel with less than a 24-hour advance notice, you will be charged a $50 missed appointment/late cancellation fee.**

I have read and understand the policy stated above.

_____

Signature Date

MEDICAL /HISTORY REGISTRATION FORM

Acknowledgement of Receipt of Notice of Privacy Practices

(You May Refuse to Sign this Acknowledgement)

I, _____, have received a copy of this offices Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other specified reason _____

  _____

_____ _____

Employee Signature Date