Nicholas K. Howland, M.D.

Patient Name		Date of Birth	Age	Sex	Email Address
Address		City	State	Zip	SSN
Home Phone	Cell Phone	Work Phone	Employer		Occupation
Emergency Contact (Not Living with You)		Relationship to patient		Emergency Contact Phone	
Insured Persons Employer		Insured Persons Date of Birth		Insured Persons SSN	
Primary Insurance Company		Policy or ID#		Insured Persons Name	
Secondary Insurance Company		Policy or ID#		Insured Persons Name	
Who can we thank for referring you here?	Phone Number	Primary Care Doctor		Phone Number	
What are you seeing the doctor for today?		Was this an accident? If so, what was the date of the accident?			

Plastic And Reconstructive Surgery

Medical Problems

What are your current Medical Problems?

_____

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Do you have any of the following medical problems?

AIDS/HIV/Hepatitis	Y ○	N ○	Anemia	Y ○	N ○	Arthritis	Y ○	N ○
Asthma	Y ○	N ○	Diabetes	Y ○	N ○	Kidney Disease	Y ○	N ○
Cancer-Breast	Y ○	N ○	Cancer-Skin	Y ○	N ○	Cancer-Other	Y ○	N ○
Heart Disease	Y ○	N ○	High Blood Pressure	Y ○	N ○	Mitral Valve Prolapse	Y ○	N ○
History of DVT or PE	Y ○	N ○	Thyroid Disease	Y ○	N ○	Tuberculosis	Y ○	N ○
Stroke	Y ○	N ○	MRSA or Exposure to MRSA	Y ○	N ○	Rheumatic Fever	Y ○	N ○

Surgeries

Please list all previous surgeries or previous illnesses including the dates:

_____

_____

Medications

Please list any medications you are taking:

_____

_____

Allergies

Do you have any allergies to medications, foods, etc.:

_____

_____

Have any of your relatives ever been diagnosed with the following?

Breast Cancer	Y ○	N ○	Skin Cancer	Y ○	N ○	Other Cancer	Y ○	N ○
High Blood Pressure	Y ○	N ○	Heart Disease	Y ○	N ○	Depression	Y ○	N ○
Diabetes	Y ○	N ○	Cleft Lip and/or Palate	Y ○	N ○	Abnormal Head Shape	Y ○	N ○

Have you now or have you ever had any of the following?

Weight Loss (Unexplained)	Y ○	N ○	Swollen Feet/Ankles	Y ○	N ○	Seizures	Y ○	N ○
Weight Gain (Unexplained)	Y ○	N ○	Skin Rash	Y ○	N ○	Joint or Muscle Pain	Y ○	N ○
Dry Eyes	Y ○	N ○	Chronic Cough	Y ○	N ○	Chest Pain	Y ○	N ○
Rapid Heart Beat	Y ○	N ○	Jaundice	Y ○	N ○	Swollen Lymph Nodes	Y ○	N ○
Easy Bleeding	Y ○	N ○	Easy Bruising	Y ○	N ○	Depression	Y ○	N ○

Social History

Occupation_____ Marital Status_____

Smoking (type and amount per day)_____ Alcohol (type and amount per week)_____

What is your current height?_____ Current Weight?_____

RACE: (circle one) Caucasian ☐ Hispanic ☐ Asian ☐ African American ☐ Other ☐

Women Only

Are you planning to become pregnant in the future? Yes ○ No ○ Do you have children? Yes ○ No ○ Breast Lumps or Discharge? Yes ○ No ○

# of Pregnancies_____ Number of children_____ Did you breast feed? Yes ○ No ○

Date of Last Mammogram_____ Do you regularly perform breast self-examinations? _____

Assignment and Release

I hereby authorize Premier Plastic Surgery to release to my insurance carrier any medical information necessary to secure payment. I authorize benefits to be made payable directly to Premier Plastic Surgery. I understand that I am financially responsible to the physician for the charges not covered by my insurance policy. I certify that all information given on the patient information sheet is complete and correct to the best of my knowledge. In the event of default of payment of the charges, the responsible party agrees to pay collection fees, including reasonable attorney fees. This assignment will remain in effect until revoked by me in writing. A photocopy or digital facsimile of this assignment is considered as valid as the original.

General Permit for Professional Care

I hereby give permission to the doctor to render treatment as he sees fit upon myself, my son or daughter, or the person whom I have guardianship and to call any consultant, anesthesiologist, laboratory personnel, etc., as he deems advisable in the care of this case. I also agree to be responsible for the charges of any such consultants, as well as those of any hospitals, surgical centers, or medical facilities that may be incurred. I understand that the office takes all precautions to make sure my insurance carrier is contracted with these facilities, but I understand my insurance company does not guarantee payment. I hereby grant permission for the use of any record, illustration, photograph or other imaging record created in my case for the use in examination, testing, education, credentialing, and/or certifying purposes by The American Board of Plastic Surgery, Inc. or any other peer review or accrediting body. I am advised that although good results are expected, they cannot be and are not guaranteed, nor is there any guarantee against untoward results.

Privacy Statement

I have received or was offered a copy of the *Notice of Privacy Practices* provided by the office in compliance with HIPPA regulations. I authorize Premier Plastic Surgery Group to release my personal health information for use in “payment, treatment, and health care operations.” Copies are available at the front desk.

Signature of Patient/Guardian **Date**

Insurance Billing

I agree to provide current insurance and billing information. If my insurance company requires a co-pay, I agree to pay it at the time of the service. I understand that I may be required to obtain a referral from my primary care physician, and if I fail to provide this referral, I will be responsible for payment of the office visit or consultation fees. I understand that my insurance company may require that I pay a portion of my bill. I understand that account balances remaining unpaid after 60 days will be subject to a finance charge. Accounts not paid in full within 90 days may be referred to collection or litigation. Collection and/or reasonable attorney fees will be borne by the responsible party.

Private Pay-Uninsured Patients

Non-emergency procedures require a 60% down payment prior to procedure. Our billing specialist is available to assist with payment arrangements. If for any reason an untimely financial situation arises, we encourage you to call our office and notify the billing specialist so arrangements can be made.

Cosmetic Patients

Cosmetic patients are required to pay a deposit equal to 10% of the price quote to secure any surgery date. This deposit is non-refundable. Payment in full for all surgeries is due one week prior to the surgery. No exceptions will be made. No personal checks are accepted. We accept credit cards, money orders and cashier checks. If you choose to finance through our finance company, all approvals must be received and signed before your surgery date.

Signature of Patient/Guardian **Date**

DID YOU READ AND SIGN ON BOTH SIGNATURE LINES? THANK YOU