

Gunn Plastic Surgery Center
Patient History Information

Patient's Full Name _____
Last First Middle

Address _____
Street City State Zip Code

Home Phone _____ Business _____ Cell _____

Social Security Number _____ Date of Birth _____ Age _____

Sex: (Circle one) Male Female Marital Status: (Circle one) Married Single Separated Divorced Widowed Partnered

Employer _____ Occupation _____

Spouse Name _____ Spouse Employer _____

Referred By _____ Email Address _____

Please tell us how you heard about our office. _____

If accident of illness, give date _____ Were you in an auto accident? YES NO

Were you injured on the job? YES NO Were you seen in a hospital? YES NO

Responsible Party

Person Responsible for payment if other than above _____

Relationship of Patient to Responsible Party: Self Spouse Child Dependent Other _____

Address _____
Street City State Zip Code

Home Phone _____ Business _____ Cell _____

SSN of Responsible Party _____ Date of Birth of Responsible Party _____

Emergency Contact

Name _____ Phone _____ Relationship _____

Insurance Information

Primary

Secondary

Insurance Company Name _____

Name of Policy Holder _____

Relationship to Patient _____

Policy # and Group # _____

Insured's Date of Birth _____

SSN of Policy Holder _____

Address for mailing claims _____

Send Claims to (Circle one) Insurance Company Patient Employer

Authorization to pay benefits to physician: I hereby authorize payment directly to Laura A. Gunn, M.D of any surgical and/or medical benefits, if any, otherwise payable to me for the Physician's services.

Signature: _____

Authorization to release medical information: I hereby authorize Laura A. Gunn, M.D to release any information acquired during the course of my examination and treatment to expedite insurance claims.

Signature: _____

Laura A. Gunn, M.D files insurance claims as a service to her patients; however, the patient is responsible for payment of their account in full. The information listed above is correct to the best of my knowledge.

Signature: _____

Date: _____

Patients Full Name _____
Address _____
City, State Zip _____
Sex: M F _____ Birth date _____

Patient Account # _____
Home Phone _____
Work Phone _____

Family History

_____ # of Children

Family Medical History (Diabetes, Heart Disease, Hearing Loss, etc.) _____

Personal History

*If you answer "yes" to any question, please explain in the space provided

In the			
Yes	Past	No	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you consume alcohol? Daily Intake _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you consume caffeine? (coffee, tea, soft drinks) Daily Intake _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use Tobacco? (cigarettes, pipe, cigar, snuff) Daily Intake _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to any medications? Latex allergy? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently taking any medication? _____

PLEASE LIST MEDS _____

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you take aspirin? (Bufferine, BC, Goodies, Anacin) Daily Intake _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to local anesthetics? (novacaine, Xylocaine, etc.) _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have allergies to tape, soaps, solutions, etc.? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Previous hospitalizations _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Previous operations? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had problems with anesthesia or surgery? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had previous allergy treatment? _____

Do you or have you ever had a history of the following:

*If you answer "yes" to any question, please explain in the space provided

In the			
Yes	Past	No	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastroesophageal reflux or ulcers? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric problems? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack, angina, or chest pain? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood pressure problems? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac pacemaker? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disease? (fainting, convulsions, etc.) _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back problems? (numbness or weakness in arms or legs) _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or yellow jaundice? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease, stones, cystitis? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease or goiter? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia or low blood? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma, bronchitis, pneumonia, abnormal chest x-ray, or sleep apnea? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently pregnant? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive bleeding when cut? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruising easily? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow healing wounds? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Keloids or excessive scarring? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives or allergic skin reactions? _____

I certify that the above information is accurate and correct to the best of my knowledge and I have not withheld information concerning my medical history.

Patient Signature (Parent/Guardian if minor) _____

Date _____

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We are required by law to maintain the privacy of your health facts and to provide you with the notice of our legal duties and privacy practices. We must follow the terms of the notice in effect right now, but we reserve the right to change the terms. If there is a change, we will provide you with a written, revised notice upon request.

As a client of ours, facts about you must be used and disclosed to other parties for treatment, payment, and health care operations. These uses and disclosures require your consent, and include, but are not limited to the following information:

- A release of information contained in financial and or medical records;
- Diseases spread person to person, such as Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)
- Drug and alcohol abuse/Psychiatric diagnosis and treatment records;
- Medical history/treatment process & Laboratory test results;
- Data from the OASIS data set (home health); any other facts.

We may release the above to:

1. Your insurance company, Medicare, Medicaid, or any other person who will pay your bill for services or who will process your bill for services in order for us to receive payment;
2. Any person from a program or an insurance company, who performs billing, quality and risk tasks, such as insurance auditors and state risk management.
3. Any hospital, nursing home, or other health care facility where you may have testing done or to which you may be admitted
4. Any assisted living or personal care facility where you live; and any doctor providing your care.
5. Family members and other people who are part of your plan for service, in such programs as CSHP, EPSDT, home health, hospice, etc. State and Federal agencies acting on behalf of programs, Medicare/Medicaid, including state surveyors or auditors for programs such as CSHP, EPSDT, PCS, WIC, STD/HIV, home health, hospice, etc. OR Other healthcare people to start treatment.

We may contact you to provide appointment reminders or news about other health programs we provide.

We are allowed to use or disclose facts about you without consent in the following situations;

1. In emergency treatment situations, if we try to obtain consent as soon as possible after treatment;
2. Where significant barriers to communicating with you exist and we determine that the consent is clearly inferred from the situation. We are required by law to provide treatment and we are unable to obtain;
3. Where the use or disclosure is required by law; for certain public health activities, such as reporting births, deaths, injuries, diseases, etc; Where we reasonably believe you are a victim of abuse, neglect, or domestic violence to a government agency authorized to receive abuse, neglect, or domestic violence reports.
4. Health care oversight activities; certain legal administrative proceedings, certain research purposes & certain law enforcement purposes; to coroners, medical examiners and funeral directors in certain situations (hospice/home health)
5. For organ, eye or tissue donation purposes (home health and/or hospice)
6. To avoid a serious threat to health and safety; for specialized military and veterans' activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions and custodial situations; and for Workers' Compensation Purposes.

We are allowed to use or disclose facts about you without consent or authorization provided you are informed in advance and given the chance to agree to, restrict, or forbid the disclosure in the following situations:

1. The use of a directory of people served by us (clinic schedules, patient schedules)
2. To a family member, friend or other person you choose, who may assist in your care or payment for care.

YOUR RIGHTS-You have the right, subject to certain conditions, to;

1. Request restrictions on certain uses and disclosures of facts about you by filling out our request form. However, we are not required to agree to the requested restrictions.
2. Receive confidential communication of protected health data by giving us another address or means of receiving health data.
3. Inspect and copy protected health data by filling out our form or amend protected health data by filling out our request form. Receive a list of disclosures made of your protected health data by filling out our request form.
4. Obtain a paper copy of this notice upon request, if you agreed to receive this notice by email, fax, or website.

COMPLAINTS-You may complain to us and the Secretary of the U.S Department of Health and Human Services if you believe that your privacy rights have been violated. There will be no retaliation against you for filing a complaint. The complaint must be filed in writing with us and must state the specific incident(s) including date, what happened and the details of the incident.

****NO SHOW AND CANCELLATION POLICY- IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT WITH ANYONE IN OUR OFFICE, PLEASE CANCEL WITHIN 24 HOURS OF THE SCHEDULED TIME OR YOU WILL BE CHARGED A \$50 FEE.****

ACKNOWLEDGEMENT-I have read this Notice or have had it explained to me. I understand this Notice and have had a chance to ask questions about any matters I don't understand.

Signature

Date