Patient History Information

PLEASE PRINT

Physician ______________________

Patient's Full Name ______________________ Last / First / Middle

Address ______________________ Street / City / State / Zip

Home Phone ____________ Business ____________ Cell ____________

Social Security Number ____________ Date of Birth ____________ Age ______

Sex: Male Female Marital Status: Married Single Separated Divorced Widowed Partnered

Employer ____________ Occupation ____________

Spouse Name ____________ Spouse Employer ____________

Referred By ____________ Email address: ____________

Please tell us how you heard of our office. ____________

Responsible Party

Person Responsible for Payment if other than above ____________

Relationship of Patient to Responsible Party: Self Spouse Child Dependant Other ____________

Address ______________________ Street / City / State / Zip

Home Phone ____________ Business ____________ Employer ____________

SSN of Responsible Party ____________ Date of Birth of Responsible Party ____________

Name and Address of: Relative Friend Neighbor (not living at same address)

Address ______________________ Name / Address / Phone

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

State in which accident occurred ____________

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	Street/PO Box	Street/PO Box
	City, State Zip	City, State Zip

Send Claims to (cirlcle one): Insurance Company Patient Employer

Authorization to pay benefits to physician: I hereby authorize payment directly to Laura A. Gunn, MD 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, MD to release any information acquired during the course of my examination and treatment to expedite insurance claims.

Signature ______________________

Photograph Consent: I give my permission for my photographs to be used for: 1) Medical Lectures 2) Scientific articles for publication 3) Presentation to other patients seeking information on plastic surgery. 4) On website

Please Initial: ________ Yes ________ No

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

Signature ______________________

Relationship to Patient ______________________

Date ______________________

Laura A. Gunn, MD does not assume responsibility for articles or valuables brought into the office. Patient must assume all responsibility for safekeeping of their articles and valuables.

Health Bio

Patients Full Name ______________________ Patient Account # ______________________

Address ______________________ Home Phone ______________________

City, State Zip ______________________ Work Phone ______________________

Sex: M F Birth date ______________________

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

* Yes	In the Past	No		
☐	☐	☐	Do you consume alcohol?	Daily Intake ________
☐	☐	☐	Do you consume caffeine? (coffee, tea, soft drinks)	Daily Intake ________
☐	☐	☐	Do you use Tobacco? (cigarettes, pipe, cigar, snuff)	Daily Intake ________
☐	☐	☐	Are you allergic to any medications? Latex allergy?	________
☐	☐	☐	Are you currently taking any medication?	________

PLEASE LIST MEDS ______________________

* Yes	In the Past	No		
☐	☐	☐	Do you take aspirin? (Bufferine, BC, Goodies, Anacin)	Daily Intake ________
☐	☐	☐	Allergies to local anesthetics? (novacaine, Xylocaine, etc.)	________
☐	☐	☐	Do you have allergies to tape, soaps, solutions, etc.?	________
☐	☐	☐	Previous hospitalizations	________
☐	☐	☐	Previous operations?	________
☐	☐	☐	Have you ever had problems with anesthesia or surgery?	________
☐	☐	☐	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

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

Laura A. Gunn, MD, 300 Crutchfield Street, Durham, NC 27704 919-471-3406

ASTIC SURGERY CENTER
URA GUNN, MD

Notice of Privacy Practices

USE AND DISCLOSURE OF PROTECTED HEATLH INFORMATION

HIS 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.

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 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 n request

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 ire 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 or alcohol abuse/Psychiatric diagnosis and treatment records;
- Medical history/treatment progress & Laboratory test results;
- Data from the OASIS data set (home health);
- Any other related facts.

nay 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 management 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;
5. Any doctor providing your care;
6. Family members and other people who are part of your plan for service, in such programs as CSHP, EPSDT, home health, hospice, etc.;
7. State and or Federal agencies acting on behalf of programs, Medicare and or Medicaid, including state surveyors or auditors for programs such as CSHP, EPSDT, PCS, WIC, STD/HIV, home health, hospice, etc.;
8. Other health care people to start treatment.

ay contact you to:

1. Provide appointment reminders or news about other health programs we provide;

re 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;
3. Where we are required by law to provide treatment and we are unable to obtain consent;
4. Where the use or disclosure is required by law;
5. For certain public health activities, such as reporting births, deaths, injuries, diseases, etc.;
6. 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;
7. Health care oversight activities;
8. Certain legal administrative proceedings, certain research purposes & certain law enforcement purposes;
9. To coroners, medical examiners and funeral directors in certain situations (home health, hospice, etc);
10. For organ, eye or tissue donation purposes (home health, hospice, etc.);
11. To avoid a serious threat to health and safety;
12. For specialized government functions, including military and veterans' activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institution and custodial situations;
13. For Workers' Compensation purposes.

e 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, t or forbid the disclosure in the following situations:

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

uses and disclosures will be made only with your written approval. That approval may be withdrawn in writing at any time, except in limited situations.

RIGHTS--You have the right, subject to certain conditions, to:

- 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.
- Receive confidential communication of protected health data by giving us another address or means of receiving health data.
- Inspect and copy protected health data by filling out our request form.
- Amend protected health data by filling out our form.
- Receive a list of disclosures made of your protected health data by filling out our request form.
- Obtain a paper copy of this notice upon request, if you agreed to receive this notice by e-mail, fax, or website.

LAINTS--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 olated. 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 t(s) including the date, what happened and details of the incident.

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

Signature -- Date ---------------------------

Plastic and Reconstructive Surgery
Aesthetic Plastic Surgery

Diplomat of The American
Board of Plastic Surgery

LAURA A. GUNN, M.D.

PLASTIC SURGERY CENTER

300 Crutchfield Street
Durham, North Carolina 27704
Telephone (919) 471-3406 Fax (919) 471-0937

1. Do you have a cosmetic or aesthetic concern (for example fine lines, wrinkles, hyperpigmentation, loss of facial volume?
2. Do you need help with skin care?
3. Have you ever been treated for a cosmetic or aesthetic concern (dysport, filler, skin tightening)?

Are there additional services you would like to learn about?

__Skin care advice
__Suncreen products
__Skin care products
__Facial injectibles/fillers
__Thin lips
__Length of eyelashes
__Fullness of eyelashes

__Chemical peels
__Blotchy skin
__Facial veins/Body
__Facial redness
__Brown Spots/age spots freckles
__Facial fullness/drooping
__Unwanted Hair
__Permanent makeup

NAME: ______________________________

D.O.B.________________________________

Contact Phone # ____________________