Gunn Plastic Surgery Center

PATIENT DEMOGRAPHIC INFORMATION

(Please Complete Entire Form)

Patient's Full Name _____
Last First Middle

Address _____
Street City State Zip Code

Home Phone _____-_____-_____ Business_____-_____-_____ Cell _____-_____-_____

Social Security Number (last 4)_____ Date of Birth _____-_____-_____ Age _____

Sex: ○ Male ○ Female ○ Other: _____

Marital Status: ○ Married ○ Single ○ Separated ○ Divorced ○ Widowed ○ Partnered

Employer _____ Occupation _____

Spouse Name: _____ Spouse Employer:_____

Referred by:_____ Pt. Email address:_____

Please tell us how you heard about our office _____

Person Responsible for payment if other than above _____ DOB: _____

Relationship of patient to responsible party ○ Self ○ Spouse ○ Child ○ Dependent ○ Other_____

Address _____
Street City State Zip Code

Emergency Contact

Name _____ Phone _____-_____-_____ Relationship _____

Insurance Information	Primary	Secondary
Insurance Company Name		
Name of Policy Holder & DOB		
Relationship to Patient		
Policy # and Group #		

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. 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.

Laura A. Gunn, M.D files insurance claims as a service to her patients; however, **the patient is responsible for their copayment at the time of check in** and all balances on their account until paid in full. The information listed above is correct. Any unpaid balance turned over to collections could result in a $25 fee.

****NO SHOW AND CANCELLATION POLICY**- WE ASK THAT YOU PROVIDE OUR OFFICE A MINIMUM OF 48 HOURS' (2 BUSINESS DAY) NOTICE SHOULD YOU NEED TO CANCEL OR RESCEDULE YOUR APPOINTMENT. IF APPOINTMENT IS CANCELED OR RESCHEDULED WITHIN THE 48 HOURS (2 BUSINESS DAY) OF APPOINTMENT TIME, OR A NO-SHOW, YOU WILL BE ASSESSED A $50 NO SHOW/ LATE CANCELLATION FEE****

REFUNDS: If original payment is made with a charge/debit card, there will be a 3% fee for both purchase and refund if approved.
If original payment is made with Care Credit, there will be a fee (to be determined at that time) for both purchase and refund if approved.

Signature:_____ Date: _____ - _____ - _____

GUNN PLASTIC SURGERY CENTER, 300 CRUTCHFIELD STREET, DURHAM, NC 27704 Tel. 919-471-3406

Patient's Full Name _____ Date of Birth _____-_____-_____

Sex: ○ Male ◉ Female ◉ Other: _____

Family History: ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Other _____

Personal History

(If you answer yes to any questions, please explain in the space provided)

To be completed by GPS staff: Height _____ BP _____ Weight _____ HR _____ Temp _____ O2Sat _____

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? (cigarette, pipe, cigar, snuff)	Daily Intake _____
○	◉	◉	Are you allergic to any medications? Latex allergy?	_____
○	◉	◉	Do you use marijuana, cocaine, or other similar drugs?	_____
○		◉	List Current Medications _____	
○	◉	◉	Do you take aspirin? (Bufferin, 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?	_____
○	◉	◉	Do you have children?	How Many _____
○	◉	◉	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 questions, please explain in the space provided)

Yes	In the past	No		
○	◉	◉	Gastroesophageal reflux or ulcers?	_____
◉	○	◉	Psychiatric problems?	_____
○	◉	◉	Heart attack, angina, Afib, arrhythmia, stent, ablation?	_____
○	◉	◉	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, lung infections?	_____
○	◉	◉	Sleep Apnea?	_____
○	◉	◉	Frequent headaches?	_____
○	◉	◉	Arthritis?	_____
◉	◉	○	Are you currently pregnant? *If yes, how far along?*	_____
◉	◉	○	Excessive bleeding when cut?	_____
◉	◉	○	Bruising easily?	_____
◉	◉	○	Slow healing wounds?	_____
◉	○	◉	Keloids or excessive scarring?	_____
◉	○	◉	Family/personal history of blood clots/ h/o blood thinner?	_____
◉	○	◉	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: _____ - _____ - _____

GUNN PLASTIC SURGERY PARTY RELEASE

Patient's Full Name _____ Date of Birth _____-_____-_____

I authorize Gunn Plastic Surgery and Associates to release protected health information about the above patient in the following manner and/or to selected person(s) when requested.

Gunn Plastic Surgery and Associates uses the following for appointments, reminders and changes, form completion, electronic statements, billing notifications, lab results, referral details, prescriptions and refills, other medical recommendations, and may request follow up regarding previous visits with your other providers.

EMAIL ADDRESS (provided by patient on demographic sheet) ○ Yes ○ No

MOBILE PHONE/HOME/WORK TEXT AND/OR
VOICEMAIL (provided by patient on demographic sheet) ○ Yes ○ No

FOR EMAIL AND/OR TEXT COMMUNICATION, I UNDERSTAND THAT IF INFORMATION IS NOT SENT IN AN ENCRYPTED MANNER THERE IS A RISK IT COULD BE ACCESSED INAPPROPRIATELY. I STILL ELECT TO RECEIVE EMAIL AND/OR TEXT COMMUNICATIONS AS SELECTED ABOVE.

Other person(s) we may contact regarding your medical information and/or financial information, please list below:

Name	Phone Number	Relation
Name	Phone Number	Relation
Name	Phone Number	Relation

PATIENT RIGHTS:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the
- recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization.

NOT SIGNING MAY AFFECT TREATMENT AS OUR ABILITY TO CONTACT PATIENT IS HINDERED

This authorization will remain in effect until revoked by the patient or until expiration of 1 year following date signed.

_____ _____

Signature of Patient/Legal Guardian Date

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.

Our Responsibilities

Company is required by law to:

- Maintain the privacy and security of your protected health information (PHI).
- Provide you with this Notice of our legal duties and privacy practices with respect to your PHI.
- Notify you promptly if a breach occurs that may have compromised the privacy or security of your information.
- Follow the duties and privacy practices described in this Notice and provide you with a copy.

Uses and Disclosures of Your Health Information

We may use and disclose your PHI for the following purposes:

- **Treatment:** To provide, coordinate, or manage your health care and related services.
- **Payment:** To obtain payment for the health care services we provide to you.
- **Health Care Operations:** For administrative and operational purposes, such as quality assessment and improvement activities.

Special Protections for Certain Information

- Substance Use Disorder Records: Certain health information that we maintain may be protected by federal law at 42 C.F.R. Part 2. These laws provide additional privacy protections for records related to substance use disorder diagnosis, treatment, or referral for treatment. We may not use or disclose Part 2 Records without your written consent, unless the law permits the use or disclosure.
- With written consent, we may use or disclose Part 2 Records as described in that consent. Information we disclose pursuant to that consent may be redisclosed by the recipient, unless expressly prohibited by law.
- Part 2 prohibits us from using or disclosing these records (or testimony about these records) in civil, criminal, administrative, or legislative proceedings against you unless you provide written consent, or a valid court order is obtained.

Your Rights

You have the right to:

- **Access:** Request to inspect and obtain a copy of your PHI.
- **Amend:** Request corrections to your PHI if you believe it is incorrect or incomplete.
- **Accounting of Disclosures:** Request a list of certain disclosures of your PHI made by us in the past six years.
- **Restrictions:** Request restrictions on certain uses and disclosures of your PHI.
- **Confidential Communications:** Request that we communicate with you about medical matters in a certain way or at a certain location.
- **Paper Copy:** Obtain a paper copy of this Notice upon request, even if you have agreed to receive the Notice electronically.

Changes to This Notice

Company reserves the right to change this Notice and make the new provisions effective for all PHI we maintain. If we make material changes to our privacy practices, we will promptly revise and distribute the updated Notice as required by law.

Complaints

If you believe that your or another person's health information privacy or civil rights have been violated, you can file a complaint with the Secretary of the Department of Health and Human Services/OCR at (https://www.hhs.gov/ocr/complaints/index.html).

If you have any questions or to file a complaint with us, contact: Attn. Privacy Officer, Gunn Plastic Surgery Center, 300 Crutchfield Street, Durham, NC 27704 Tel. 919-471-3406 or GunnPlasticSurgery@gunnmd.com

You will not be penalized for filing a complaint.

Patient Signature_____ Date_____