

North Texas Plastic & Reconstructive Surgery

Please help us to assure you the highest quality care by answering carefully

Legal Name: _____

Mailing Address: _____

Street Address apt # City State zip

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Cell:(____) _____ - _____ Email Address: _____

Sex: M F Age: _____ Date of birth: _____

S.S. # _____ DL _____ St _____

Employer: _____ Occupation: _____

Business Address: _____

Marital Status: Single Married Widowed Divorced Other: _____

Name of Spouse: _____ D.O.B. _____

SS#: _____ Employer: _____

Telephone: _____ work/cell: _____

Emergency Contact: _____ Relation to you: _____

Home Phone: _____ Daytime/cell: _____

If patient is under 18 years of age:

Fathers Name: _____ D.O.B. _____ SS#: _____

Employer: _____ Work #: _____

Mothers Name: _____ D.O.B. _____ SS#: _____

Employer: _____ Work#: _____

Release of Medical Information & Assignment of Benefits

Office services are to be paid at the time of services rendered. All visits/procedures are to be prepaid unless prior arrangements have been made. As part of your PPO/HMO plans we will be glad to file your insurance, we extend 30 days for coordination of benefits, the balance is due 45 days from the time of service for any coinsurance/deductibles/non-covered services.

I authorize the release of any medical information to process this claim. I also request payment of Government Benefits either to myself or to the party who accepts assignment.

Signed: _____ Date: _____

I authorize payment of medical benefits to North Texas Plastic & Reconstructive Surgery, Charles T. Slack, M.D.

Signed: _____ Date: _____

What is the reason for this visit? _____

How did you hear about our office? _____

Current Medications

Please list all medication(s) and Dosage(s)

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Pharmacy # _____

Do you take any diet medications ? _____ please list _____

Do you use any non prescription medications/herbal/vitamins?: Yes No

If yes, please list: _____

Name of Personal Physician: _____

Address: _____

Telephone: _____ Fax: _____

Specialty: _____

Drug Allergies and Reactions

Medication(s): _____

What type of reaction(s) did you have: _____

Have you ever had a reaction to: Tape/Latex/Soap(s)/Food(s): _____

If yes, what type of reaction(s) did you have: _____

Family History

Circle any of the following that effect first-degree relatives

High Blood pressure

Heart Disease

Breast Cancer

Diabetes

Bleeding disorders

Mental Illness

Hereditary Disease

M.D. Initials _____

Medical History

Please check if you have had the following:

- | | |
|--|---|
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Immune disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Irregular heartbeat/palpitations |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Eyes burning | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Fainting or blackout episodes | <input type="checkbox"/> Lung/respiratory problems |
| <input type="checkbox"/> Heart disease and/or attack | <input type="checkbox"/> Prolonged bleeding when cut |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Heart valve disorder | <input type="checkbox"/> Skin disorders |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Herpes, fever blisters | <input type="checkbox"/> Swelling of ankles |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Ulcer disease |

If you checked any of the above please explain: _____

Personal Health Habits

Do you smoke? Yes No If Yes, How Much? _____

Do you drink alcohol? Yes No If Yes, How Often? _____

Height: _____ Weight: _____

Exercise Habits: _____

Date of last menstrual period: ____/____/____ Are you Pregnant? Yes No

Number of pregnancies: _____ Live births: _____

Date of Last Mammogram: ____/____/____ What Facility: _____ Results: _____

Surgical History

Please list any surgeries and Dates: _____

Have you or anyone in your family had a reaction to general anesthesia? Yes No

If yes, please explain: _____

Have you formed excessive or unsatisfactory scars in the past? Yes No

If yes, please explain: _____

Have you ever had a blood transfusion? Yes No

If yes, please explain: _____

M.D. Initials _____

North Texas Plastic & Reconstructive Surgery

In our efforts to comply with the health information privacy act, HIPAA, we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Please circle your choice response to the following questions:

May we leave messages on a voice mail at work? Yes No

May we leave messages concerning your appointments/treatment with a co-worker, Receptionist, or secretary that regularly answers your calls? Yes No

May we leave messages on an answering machine at home? Yes No

May we leave information with a spouse or significant other? Yes No

Is there anyone that is not listed above that we can give Information to? If so, please specify?

For any children above 18, still living at home, may we discuss? Yes No

Your appointments/treatment with your parent(s) or Guardian? Yes No

You must inform us, in writing of any changes in your directive. This record takes effect April 14, 2003 and will be kept in your file along with your acknowledgment of receipt of our Notice of Privacy Practices.

Signature: _____ Date: _____

Receipt of Notice of Privacy Practices Written Acknowledgment Form

I _____ have been allowed to review/and have been offered a copy of North Texas Plastic and Reconstructive Surgery Privacy Practices.

I _____ have received a copy of North Texas Plastic and Reconstructive Privacy Practices.

Dr. Charles Slack feels obligated to inform you that he has a financial interest in The Surgery Center at Craig Ranch in McKinney, Texas. He also operates out of the following facilities: Presbyterian Hospital of Allen, Centennial Medical Center Frisco, and Medical City Dallas.

Signature of Patient

Date

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