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:_____
Last 4 digits of S.S. #_____ DL _____St_____

Employer:_____Occupation:_____
Business Address:_____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced □ Other: _____

Name of Spouse:_____D.O.B._____
Last 4 digits of S.S. #_____
Employer:_____
Telephone:_____work/cell:_____

Emergency Contact: _____ Relation to you:_____
Home Phone:_____Daytime/cell:_____

If patient is <u>under</u> 18 years of age:
Fathers Name:_____D.O.B._____
Last 4 digits of S.S. #_____ Employer:_____
Work #:_____
Mothers Name:_____D.O.B._____ Last 4 digits of S.S. _____
Employer:_____Work#:_____

<u>Release of Medical Information & Assignment of Benefits</u>

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: _____

Patient Name: _____ 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 name and location: _____
Pharmacy phone #_____

Do you take any diet medications ?_____please list_____
Do you use any nonprescription medications/herbal/vitamins?: ☐ Yes ☐ No

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_____

Patient Name: _____ Date:_____

Medical History

Please check if you have had the following:

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

If you checked any of the above please explain: _____
_____
_____

Do you have any mental health issues, are you currently seeing a psychiatrist?: ☐ Yes ☐ No

Personal Health Habits

Do you now or have you ever smoked, Vaped, or used any other nicotine product including Chewing tobacco? ☐ Yes ☐ No If yes, How much and how often?_____
Do you drink alcohol? ☐ Yes ☐ No If Yes, How Often?_____
Height:_____Weight:_____
Exercise Habits:_____
Date of last menstrual period: ____/____/____ Are you Pregnant? ☐ Yes ☐ No

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
Limited Patient Authorization for disclosure of Protected Health Information

Patient Name:
_____*DOB:*_____

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.

Who is authorized to receive information?
Name:_____relationship:_____Ph:_____
Name:_____relationship:_____Ph:_____
Name:_____relationship:_____Ph:_____

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

Expiration of this Authorization:

This authorization will expire 1 year from the date of your signature below, unless you specify otherwise. You must sign a new authorization after the expiration date to continue authorization. You have the right to terminate this authorization at any time by notifying the Privacy Manager in writing.

Signature:_____Date:_____

Authorization renewal/changes:
Signature:_____Date:_____
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 Texas Health Surgery Center Craig Ranch in McKinney, Texas. He also operates out of the following facilities: Texas Health Presbyterian Hospital of Allen, Methodist Hospital of McKinney, and Baylor Hospital of McKinney

Signature of Patient

Date

NORTH TEXAS
PLASTIC AND RECONSTRUCTIVE SURGERY
CHARLES T. SLACK, MD

Waiver for Use of Text for PHI Information

In order to effectively meet our patients' chosen means of communication, with your consent, North Texas Plastic and Reconstructive Surgery can send appointment and exam confirmations and reminders and other related communications regarding your care and/or your account via text[1].

However, no protected health information (PHI) will be transmitted via text messages without your prior approval. **Because public (unencrypted) text messaging is an unsecured form of communication, there is a risk that information contained in text messages may be misdirected, intercepted or improperly disclosed.** Therefore, if you desire to receive OR SEND information to/from North Texas Plastic and Reconstructive Surgery, its staff and representatives using text, we require your consent to the following: By signing this Consent Form, I _____ (insert your name) hereby agree to ALL of the following:

- ☐ North Texas Plastic and Reconstructive Surgery can send appointment and exam confirmations and reminders and other related communications regarding my care and/or your account via text to the following number: (____) _____-_____
- ☐ **Information and images received by text by North Texas Plastic and Reconstructive Surgery, its staff and representatives will be deleted (after use) from any mobile device(s) on which it was received, and may be printed and/or filed separately as part of your permanent and secure Medical Record.**
- ☐ I accept that I am solely responsible for any information I choose to send to North Texas Plastic and Reconstructive Surgery, its staff and representatives via text, and hereby hold harmless North Texas Plastic and Reconstructive Surgery, its staff and representatives for any and all information/images I send which are improperly received by unauthorized persons.
- ☐ I understand that texts received by North Texas Plastic and Reconstructive Surgery, its staff and representatives without this waiver being signed by me cannot be accepted or acted upon, and will be deleted immediately.
- ☐ I retain the right to revoke this consent at any time, however such revocation does not cover messages sent or received in the period of time between the signing of this consent and its revocation. I may revoke this Consent by sending a request **in writing** to The HIPPA Security Officer, 8105 N. Central Expressway, Suite 370, Texas 75013.

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT FORM AND CONSENT AND AGREE TO ITS TERMS. I UNDERSTAND THAT TREATMENT IS NOT CONDITIONED ON MY SIGNING THIS CONSENT. I AM THE PATIENT OR AM PROPERLY AUTHORIZED TO ACT ON BEHALF OF THE PATIENT.

Date: _____

Signature of Patient

Please Print Patient's Name

Signature of Person Signing on Behalf of Patient*

Please Print Authorized Representative's Name

* Representative's relationship to Patient:

For Office Use Only:

Received by Sign ___ Logged in Server
_____ Employee's
Initials _____ Date

[1] Applicable fees remain your responsibility.

INSURANCE AGREEMENT

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For Office Use Only:

Reviewed to Sign ___ Logged in Server
_____ Employee's
Initials _____ Date

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