PLASTIC SURGEONS OF ALASKA

Jana K. Cole, M.D.
Daniel W. Suver, M.D.
Aesthetic and Reconstructive
Plastic Surgeons of Alaska, LLC

Thank you for choosing our office. In order to serve you properly, PLEASE PRINT the following information.

Name:			Nickname:	Today's date

MAILING Address:	City	State	Zip	DL# & state

AGE:	Birthdate:	SSN:	Height:	Weight:	Marital Status:	Gender:

	May we contact you here?		May we leave a message ?	
Home Ph:	YES	NO	YES	NO
Work Ph/Ext :	YES	NO	YES	NO
Cellphone:	YES	NO	YES	NO

E-mail:
May we email you information about the office or your appointments? Yes or No

Occupation:	Employer:
Address:	
Spouse's Name, Occupation and Employer	
Emergency Contact Name:	Relationship:
ER Contact Home Ph:	ER Contact Work Ph:

If patient is a minor:	Father's Name:	Work Phone
Father's Employer:		
Mother's Name:		Work Phone:
Mother's Employer:		

PAYMENT FOR OFFICE VISITS OR OFFICE PROCEDURES IS REQUIRED AT THE TIME OF THE APPOINTMENT. WHEN POSSIBLE AN ESTIMATE OF THE CHARGES INVOLVED WILL BE GIVEN AND YOU WILL BE PROVIDED A RECEIPT FOR FILING WITH YOUR INSURANCE.

Primary Insurance Co:		
Insured Party:	ID No:	Group No:
Ins Company Address:		
Secondary Insurance Co:		
Secondary Insured Party:	ID No:	Group No:
Ins Company Address:		

PLEASE PROVIDE COPIES OF INSURANCE CARDS

MEDICAL INFORMATION

PATIENT NAME: ____

REASON FOR OFFICE VISIT TODAY (PLEASE BE SPECIFIC)______________________________

____

REFERRED BY (NAME OF PHYSICIAN OR FRIEND)____________________________________

IF INJURED, DATE OF INJURY__________________DID THIS OCCUR AT WORK?____________

HAVE YOU SEEN DR. MANUEL, DR. COLE OR DR. SUVER BEFORE? _______________________

IF SO, WHEN?____

NAME OF USUAL PHYSICIAN____

PAST SURGERY____

____

KNOWN MEDICAL PROBLEMS (IF NONE , WRITE NONE)______________________________

____

____

DO YOU SMOKE CIGARETTES OR USE ANY TOBACCO PRODUCTS? INCLUDING VAPING?
DO YOU SMOKE MARIJUANA? YES( ) NO( )

HAVE YOU BEEN TESTED FOR THE HIV (AIDS) VIRUS? YES( ) NO( )

RESULTS_____________________________________DATE OF TEST__________________

TO YOUR KNOWLEDGE HAVE YOU BEEN EXPOSED TO HIV? YES( ) NO( )

I HEREBY AUTHORIZE DR. COLE AND DR. SUVER OR THE OFFICE STAFF TO TAKE AND MAINTAIN PRE & POST OPERATIVE PHOTOGRAPHS AS A PART OF MY MEDICAL CHART.

SIGNATURE OF PATIENT OR GUARDIAN _________________________DATE______________

PATIENT NAME_________________________________ DATE____________

ALLERGIES: *please check one*
_______ I have no medication allergies
_______ I have medication allergies. Please list and describe what happens:
____
____
____
____

If you take any of the listed medications below, please check.

_______ Buprenorphine *(e.g., Suboxone, Subutex, Bunavil, Zubsolv, Sublocade)*
_______ Naltrexone *(e.g., Revia,Vivitrol, Contrave)*
_______ Phentermine *(e.g., Apidex, Lomaira, Suprenza, Qsymia)*

CURRENT MEDICATIONS: (including aspirin, non-prescription medications, vitamins and naturopathic medications)

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

PAIN MANAGEMENT: *please check one*
_______ No, I am NOT currently taking opioid or narcotic medications for pain
_______ Yes, I am currently taking opioid or narcotic medications for pain

Please list the opioid or narcotic medications you are currently taking
(*e.g., Oxycodone, Hydrocodone, Dilaudid, Norco, Fentanyl, Methadone, Hydromorphone, Percocet, Oxycontin*)

____
____
____

ASSIGNMENT AND RELEASE

I hereby irrevocably authorize my insurance company/ fund to pay benefits for services directly to Plastic Surgeons of Alaska, LLC. ***if I have not paid in full myself****. Furthermore,* ***I understand that I am financially responsible for costs associated with my treatment.*** *I also authorize Plastic Surgeons of Alaska, LLC to release any information required to process a claim, including but not limited to insurance companies, health care service plans, worker's compensation carriers and government services.*

PATIENT'S SIGNATURE: ________________________ **DATE** ________________

IF PATIENT IS A MINOR:

PARENT/GUARDIAN SIGNATURE ________________________ ***DATE*** ________________

RELATIONSHIP TO MINOR ____

PRIVACY

I understand the Federal Government has placed restrictions on the exchange/release of patient medical information. In cooperation with these regulations and to facilitate better and more rapid exchange of information, I offer consent to the release of information to other treating physicians or health care providers, hospitals, my insurance company (or other payers), or collection agencies in matters of payment dispute. I understand this information may be exchanged via mail, fax, other electronic media (e-mail), telephone or orally. **All attempts will be made to keep this information STRICTLY confidential.**

☐ Notice of Privacy Practices has been made available to me and I understand that I may request a paper copy.

PATIENT'S SIGNATURE: ________________________ **DATE** ________________

IF PATIENT IS A MINOR:

PARENT/GUARDIAN SIGNATURE ____________ ***Relationship*** ____________ ***DATE*** ________________

THIS OFFICE COMMUNICATES BY TELEPHONE ONLY....WE ASK THAT IF YOU CAN'T TAKE OUR CALL YOU CALL US BACK IMMEDIATELY. WE NEED TO BE ABLE TO CONFIRM APPTS AT 24 HOURS PRIOR, PLEASE AKNOWLEDGE YOU HAVE READ THIS AND UNDERSTAND THE POLICY(initial)______________