



PLASTIC SURGEONS
OF ALASKA

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

Please print the following information. Thank you.									
Full Name				Nickname			Today's date		
Mailing Address				City		State	Zip	DL# & state	
Age	Birthdate	SSN		Height	Weight		Marital Status		Gender
Home Phone:				<i>May we leave a message ?</i>					
				YES			NO		
Mobile Phone:				YES			NO		
				May we email you information about the office or your appointments? Yes or No					
Preferred E-mail:									
Occupation:				Employer:					
Emergency Contact:				Relationship:					
Emergency Contact Number:									
If Patient is a Minor:									
Parent or Guardian Name:									
Relationship to Minor:					Mobile Phone:				
Alternative Phone:									

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 Company:		
Insured Party:	ID No:	Group No:
Ins Company Address:		
Secondary Insurance Company:		
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 PROVIDER OR FRIEND) _____

IF INJURED, DATE OF INJURY _____ **DID THIS OCCUR AT WORK?** _____

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

NAME OF PRIMARY PHYSICIAN _____

PAST SURGERY _____

KNOWN MEDICAL PROBLEMS _____

DO YOU USE ANY NICOTINE PRODUCTS? YES NO

DO YOU SMOKE MARIJUANA? YES NO

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

I HEREBY AUTHORIZE DR. COLE, DR. LEE, 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 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 SIGNATURE: _____ **DATE** _____

IF PATIENT IS A MINOR:
PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

RELATIONSHIP TO MINOR _____

THIS OFFICE COMMUNICATES BY TELEPHONE ONLY. WE ASK THAT IF YOU ARE UNABLE TO TAKE OUR CALL, PLEASE CALL US BACK IMMEDIATELY. WE NEED TO BE ABLE TO CONFIRM APPOINTMENTS 24 HOURS PRIOR. PLEASE ACKNOWLEDGE YOU HAVE READ AND UNDERSTAND THE POLICY.

(initial) _____