PLASTIC SURGEONS OF ALASKA

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Aesthetic and Reconstructive Plastic Surgeons of Alaska, LLC

Please print the following information. Thank you.

Full Name				Preferred Name		Today's date	
Mailing Address		City	State	Zip	DL# & state		
Age	Birthdate	SSN	Height	Weight	Marital Status	Gender	

	May we leave a message ?	
Home Phone:	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. ONCE AVAILABLE, AN ESTIMATE OF THE CHARGES INVOLVED WILL BE GIVEN.

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?_____________

ARE YOU A PREVIOUS PATIENT OF PLASTIC SURGEONS OF ALASKA? IF YES, PHYSICIAN?

____

NAME OF PRIMARY PHYSICIAN____

PAST SURGERY____

____

KNOWN MEDICAL PROBLEMS____

____

____

DATE OF MOST RECENT MAMMOGRAM ______________________

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, DR. BERHANU 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*)

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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)_______________