PLASTIC SURGEONS OF ALASKA

Jana Cole, MD
Daniel Suver, MD
James Lee MD
Aaron Berhanu, MD
Aesthetic and Reconstructive Plastic Surgeons of Alaska, LLC

Please print the following information.						
Full Legal Name			Preferred Name		Today's date	
Mailing Address	City	State	Zip	DL# & State		
*Please provide **physical address** if mailing address is a P.O. Box:*						
Age	Birthdate	SSN	Height	Weight	Marital Status	Gender
Mobile Phone:			**Home Phone:**			
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 SPECIFY AREA OF CONCERN)

_____

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

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*)

_____

_____

_____

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_____