

PREMIER PLASTIC SURGERY, PC
ACQUA BLU MEDICAL SPA & PLASTIC SURGERY CENTER
Brian Heil, MD FACS, Board Certified Plastic Surgeon
Ana Cristina Busquets, MD, FAAD, Board Certified Dermatologist

PATIENT REGISTRATION

Thank you for choosing our practice. In order to serve you properly, we need the following information. All information will be confidential. Please print.

Reason for today's visit: _____

Was this due to an accident? YES / NO. Date of accident _____ If yes, was this a motor vehicle or worker's compensation accident (please circle one).

Patients Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Marital Status: S M W D Sep Sex: _____ Social Security #: - _____

E-mail address: _____

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Do you have medical insurance: YES / NO If no, how do you intend to pay today? Cash Check Credit Card
Insurance name & address: _____

Subscriber Name: _____ Subscriber's Employer: _____

Policy#: _____ Subscriber's DOB: _____

Group #: _____ Is this through your employer? YES NO

Subscriber's Social Security # _____ Is there additional insurance? YES NO

2nd Insurance Name & address: _____

Subscriber Name: _____ Policy#: _____

Group# _____ Relationship to patient: _____

Primary Care Physician: _____ Phone# _____

Emergency contact name, relationship & phone#: _____

How did you hear about our Practice: _____

(Patient, parent/guardian signature)

(Today's Date)

03/09

PREMIER PLASTIC SURGERY
DERMATOLOGY HEALTH HISTORY FORM

PATIENT NAME: _____ DOB: _____

Please answer all questions as accurately as possible. If you do not understand the question, please ask for assistance.

Height: _____ Weight: _____

I. DERMATOLOGY HEALTH HISTORY Have you had or do you currently have any of the following conditions? Please place a check mark next to them

Diagnosis	Currently have	Have had	Duration/how long ago?
Acne			
Actinic keratosis			
Atypical moles (dysplastic nevi)			
Basal cell carcinoma			
Cysts			
Chickenpox			
Dermatitis/eczema			
Hair disorder			
Herpes simplex			
Hives			
Hyperhidrosis (excessive sweating)			
Lupus			
Melanoma			
Nail disorder			
Rosacea			
Sarcoid			
Scars/keloids			
Shingles			
Skin ulcer			
Squamous cell carcinoma			
Other skin cancer			
T cell Lymphoma (mycosis fungoides)			
Vitiligo			
Warts			
Other (specify)			

Additional information (physician will fill out):

II. **PAST MEDICAL HISTORY:** Have you ever had any of the following conditions? Please place a check mark next to them

Arthritis		Heart disease	
Asthma		Heart valve disorder	
Anemia		Hepatitis/Liver disease	
AIDS or HIV+		High Blood pressure	
Bleeding disorder		Osteoporosis or osteopenia	
Cancer (non-skin)		Pacemaker	
Cataracts		Rheumatic Fever	
Complications with anesthesia		Seizure/epilepsy	
Crohns Disease/Colitis		Stomach ulcer	
Depression/Mental illness		Stroke/TIA	
Diabetes		Thyroid disease	
Glaucoma		Tuberculosis	
Gynecologic problems		Renal disease or kidney stones	

Additional information (physician will fill out):

III. **PAST SURGERIES and DATES:**

IV. **FAMILY HISTORY** Please check any of the following conditions which a blood relative may have had

Acne		Psoriasis		Heart disease	
Atypical moles		Vitiligo		High blood pressure	
Eczema		Sarcoid		Kidney disease	
Lupus		Depression or mental illness		Stroke	
Melanoma		Diabetes		Thyroid disease	
Other <i>skin</i> cancer		Other cancer (breast, colon, pancreas, etc)		Vitiligo	

Other:

V. REVIEW OF SYSTEMS: Do you have now or have had within the past year? Please place a check mark next to them.

Fatigue		Nausea/vomiting or diarrhea	
Fevers/chills/night sweats		Joint or muscle pain	
Weight loss		Depression or mood change	
Weight gain		Swellings hands/feet	
Headaches		Swollen glands	
Dizziness		Easy bleeding	
Difficulty sleeping		Easy bruising	
Blurry vision		Dry skin	
Dry or itchy eyes		Itchy skin	
Ringing in the ears		Oily skin	
Nose bleeds		Sensitive skin	
Chronic or recurrent cough		New or changing lesions/moles (size/color)	
Wheezing		Irritated or bleeding lesions	
Chest pain		Hair loss	
Rapid or irregular heart beat		Nail changes	
Abdominal pain			

Additional information (physician will fill out):

VI. List all current MEDICATIONS/SUPPLEMENTS:

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

Any others: _____

Retin-A?	Yes	No
Strength:		
Time in use:		
Accutane?	Yes	No
Last in use:		
Tetracyclines?	Yes	No

VII. ALLERGIES:

No known drug allergies

OR

To oral medications? _____

To foods or topical products (please place a check mark next to each of them):

Adhesives		Eggs		Citrus fruit		Ragweed	
Aloe vera		Milk		Pineapple		Hydroquinone	
Alcohol based products		Nuts		Shellfish/seaweed		Retin A retinoids	
Dyes		Papaya/kiwi		Garlic,onions,chives		LATEX	
Perfumes		Strawberries		Plants or flowers			

Any others: _____

VIII. SOCIAL HISTORY:

Occupation:			
Smoker?	Current # cigarettes:	Previous Quit date:	Never
Alcohol?	Current # drinks:	Previous Quit date:	Never
Skin cancer risk	Burn	Burn-Tan	Tan
Do you use tanning booths?	Yes How often?		No
Sunscreen use?	Yes		No
Have you ever had chemical peels or microdermabrasion?	Yes		No
Do you wax or laser for hair removal?	Yes		No
Have you recently had facial surgery or facial resurfacing?	Yes		No
Botox or Fillers?	Yes		No
What is your ethnic background?			
Do you exercise regularly?	Yes How often:		No
Were you sent by another doctor for consultation?	Yes Who:		No

IX. Female clients only: Check Yes or No

YES

NO

Breastfeeding?		
Oral Contraceptives?		
Hysterectomy?		
Peri-menopausal?		
Pregnant or trying?		

I verify that the above information is true and accurate to the best of my knowledge.

X_____ Date_____

(Signature of patient or parent/guardian if minor)

**PREMIER PLASTIC SURGERY
AUTHORIZATION / ASSIGNMENT / RELEASE / CONSENT**

PATIENT NAME: _____

MEDICARE: Statement to permit payment of Medicare benefit to physician, provider, and patient.

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carries any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

If you have:

MEDICAID: Statement to permit payment of medical benefits to physician and provider.

I certify that the information given to me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Department of Public Welfare or its intermediaries or carries any information needed for this or related Medicaid claim. I request that payment of services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to D.P.W. for payment.

ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical benefits per appropriate assignment(s) to Premier Plastic Surgery, PC. I understand that I am ultimately responsible to the physician for charges not covered by my insurance. All co-insurance and deductibles are my responsibility per my contract with my insurance company.

Patient or Authorized Person

Date

RELEASE OF INFORMATION

I authorize the release of medical records, any related studies, and other information to my family physician, the doctor to whom I am referred, my legal counsel and to the applicable third-party payer.

Patient or Authorized Person

Date

PHOTOGRAPH CONSENT

I agree that Dr. Brian V. Heil MD, Ana C. Busquets, MD or designated representatives or the practice may take and use pre-treatment, pre-operative, post-treatment and post-operative photographs of my person for confidential clinical record purposes, and that such photographs shall remain the property of Premier Plastic Surgery, PC and Acqua Blu Medical Spa.

Patient or Authorized Person

Date

Witness

Premier Plastic Surgery, PC

Brian Vassar Heil, MD FACS	Board Certified, Plastic Surgeon
Ana Cristina Busquets, MD FAAD	Board Certified, Dermatologist

Premier Plastic Surgery and Acqua Blu Medical Spa
Financial Policy

Welcome and thank you for choosing our Practice. Your clear understanding of your **Patient Financial Policy** is important to our professional relationship. Carefully review the following information and return this form with your signature and today's date. Please ask if you have any questions about our fees, our policies, and/or your responsibilities.

Insurance – When making an appointment with your Provider, it is responsibility confirm with your insurance company that the Provider is currently under contract with the plan. If your plan requires that you have a referral prior to seeing a specialist, please contact your primary care physician so that you have the referral at the time of your appointment. If you do not have your referral at the time of your appointment, you will need to reschedule your appointment, or choose to be seen without the insurance benefits and pay for your visit in full. You are responsible for knowing your insurance benefit coverage. We will gladly file your insurance claim on your behalf. We allow 45 days from the date the claim is filed for the insurance company to pay. If the insurance company does not pay within this time, you will be responsible for the balance. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria, i.e. deductibles, non-covered service/surgeries, co-insurance, coordination of benefits, or pre-existing conditions. When we bill you, we will make sure that all of the information sent to the insurance company is accurate and clearly describes the services you received.

Payment is expected on the same day of each cosmetic visit prior to the physician encounter. We accept cash, checks, Visa, MasterCard, and American Express. Medical treatments/services sold as packages are non-refundable.

Occasionally an *established* patient incurs unusually high financial responsibility for charges provided by one of the providers. We will work with these patients to establish an appropriate payment plan.

In the interest of prudent medical care, all excisions are sent to an outside laboratory for pathology. The patient will receive a bill in accordance with their insurance plan.

AUTHORIZATION / FINANCIAL INFORMATION

1. I hereby authorize the release of medical information to my insurance company concerning my medical condition and treatment for the purpose of claim payment.
2. I assign Premier Plastic Surgery ALL payments from my insurance company for medical services rendered to myself and dependents.
3. I agree that if my insurance company sends payment to me for the medical services instead of Premier Plastic Surgery, I will immediately pay the amount due to Premier Plastic Surgery.
4. I agree it is my responsibility to understand my insurance benefits and to notify Premier Plastic Surgery immediately of any changes to my insurance coverage.

5. I fully understand that I am financially responsible for any co-payments, deductibles, co-insurance, cosmetic or non-covered services as determined by my insurance carrier.

A copy of this letter will remain signed in our chart as proof of this understanding.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

rev.8/11

**Premier Plastic Surgery
Acqua Blu Medical Spa & Plastic Surgery Center
Brian Vassar Heil, MD FACS
Ana Cristina Busquets, MD FAAD
144 Emeryville Drive, Cranberry Twp., PA 16066
1614 Washington Rd., Upper St. Clair, PA 15241**

RELEASE OF INFORMATION

To insure proper and timely handling of your medical information which have been ordered by you by your healthcare provider, please fill out the following information:

Home # _____
Work # _____
Cell # _____
Email address: _____

I authorize the above named physician to release any and all medical test results or other medical information related to my treatment to:

Please initial your choice(s)

- May leave message at work to contact the office.
 May leave message on answering machine at home/work/cell to contact the office.
 May contact me via e-mail
 May release medical information to spouse: Name: _____
 May release medical information to parents(s):
Parent: _____
 May release medical information to designated person
Name: _____

I understand this release will be in effect unless changed or revoked by myself either in writing or by completing a new release.

I also understand that super information is not included in this release, i.e., HIV, mental health, drug/alcohol, and sexually transmitted disease information.

I acknowledge that I have received the Premier Plastic Surgery/Acqua Blu Medical Spa & Plastic Surgery Center. Notice of Privacy Practices ("Notice").

DATE: _____
PATIENT NAME: _____
ADDRESS: _____
DATE OF BIRTH: _____
SIGNATURE: _____

PRINT NAME: _____
(Patient or Authorized Representative)

(Patient or Authorized Representative)