

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, PC

Brian Vassar Heil, MD FACS
Ana Cristina Busquets, MD FAAD

Board Certified, Plastic Surgeon
Board Certified, Dermatologist

PLASTIC SURGERY – Health History

Name: _____ DOB: _____ Today's Date: _____

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

Height: _____ Weight: _____ Allergies: _____ Latex Allergy: Yes No

Do you drink alcohol? If so how much? _____ Do you smoke, if so how much? _____

Current medications/including aspirin and vitamins:

Past surgeries and dates: _____

WOMEN ONLY (if considering breast surgery):

Bra size: _____ Age period began: _____ Date of last period: _____ # of pregnancies _____

Could you be pregnant? _____ Did you breast feed? _____ Date of last mammogram: _____

Do you perform self breast exams? _____ Have you every had/found breast lumps or discharge? _____

FAMILY HISTORY Does/has blood relative have/had the following?

Breast cancer	Yes	No	High blood pressure	Yes	No
Stroke	Yes	No	Heart disease	Yes	No
Melanoma	Yes	No	Diabetes	Yes	No
Complications with Anesthesia	Yes	No	Kidney disease	Yes	No
Depression	Yes	No	Mental illness	Yes	No
Other:					

PAST MEDICAL HISTORY Have you ever had the following?

Heart Disease	Yes	No	Unusual bleeding	Yes	No	Stomach ulcers	Yes	No
Arthritis	Yes	No	Mitral valve prolapse	Yes	No	Kidney disease	Yes	No
Asthma	Yes	No	Rheumatic fever	Yes	No	Stoke	Yes	No
Anemia	Yes	No	Thyroid disease	Yes	No	Cancer	Yes	No
Tuberculosis	Yes	No	AIDS or HIV +	Yes	No	Glaucoma	Yes	No
Diabetes	Yes	No	High blood pressure	Yes	No	Hepatitis	Yes	No
Kidney Stones	Yes	No	Mental illness	Yes	No			
Complication with Anesthesia	Yes	No						

REVIEW OF SYSTEMS Have you have now or have had within the past year?

Weight gain	Yes	No	Swollen feet/ankles	Yes	No	Seizures	Yes	No
Dry eyes	Yes	No	Joint or muscle pain	Yes	No	Skin rash	Yes	No
Chronic cough	Yes	No	Chronic diarrhea	Yes	No	Chest pain	Yes	No
Jaundice	Yes	No	Swollen lymph nodes	Yes	No	Easy bleeding	Yes	No
Depression	Yes	No	Rapid heart beat	Yes	No	Easy bruising	Yes	No
Pneumonia	Yes	No	Bronchitis	Yes	No	Colitis	Yes	No

Other: _____

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

Signature: X _____ Date: _____ 04/09

**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 your responsibility **to** 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. Before 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