Attachment A

PATIENT INFORMATION

ACCT# _____ PAT NAME: _____ DOB: _____ PCP: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: _____ WORK #: _____ CELL # : _____

MARITAL STAT: _____ SEX: _____ SS#: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____ CITY, STATE, ZIP: _____

EMERGENCY CONTACT: _____ PHONE: _____ RELATIONSHIP: _____

PERSON FINANCIALLY RESPONSIBLE:

SSN: _____ NAME: _____ DOB: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: _____ WK PHONE: _____

RELATIONSHIP TO PAT: _____ EMPLOYER: _____

PRIMARY INSURANCE NAME: _____
(Please present card for copying)
SUBSCRIBER NAME: _____ DOB: _____ EMPLOYER: _____
POLICY #: _____ GROUP #: _____ RELAT. TO PAT.: _____

SECONDARY INSURANCE NAME: _____
(Please present card for copying)
SUBSCRIBER NAME: _____ DOB: _____ EMPLOYER: _____
POLICY #: _____ GROUP #: _____ RELAT. TO PAT.: _____

IF INJURY OR ACCIDENT RELATED, PLEASE COMPLETE THE FOLLOWING:
Circle one: WORK COMP AUTO OTHER DATE OF INJURY: _____
DETAILS OF INJURY: _____

CONSENT TO TREAT:
I voluntarily consent to medical treatment and procedures that may be performed on me during this visit. This includes, but is not limited to, medical or surgical care, x-rays, test, medications, injections, laboratory tests, or other services which may be ordered by the physician participating in my care.

ASSIGNMENT OF INSURANCE BENEFITS, PAYMENTS AND RELEASE OF MEDICAL RECORDS
I hereby authorize payment of medical benefits to Exempla Healthcare. I further authorize the release of any medical/surgical information necessary for determining the extent of third party coverage and for processing an insurance claim on my behalf. I permit a copy of this authorization to be as valid as the original. I understand that I am ultimately responsible for and agree to pay all charges and expenses of the clinic for services, supplies and food furnished to me which are not paid through benefits for prepaid healthcare, insurance plans or medical assistance. If for any reason my account is forwarded to a collection agency or attorney for non-payment, I agree to pay all collection costs, court costs, attorney's fees and other reasonable costs incurred if I am found liable for amounts due to Exempla Healthcare.

This authorization must be signed by patient or responsible Party/Guarantor in the case of a minor or when patient is physically or mentally incompetent.

_____ _____
Patient or Responsible Party/Guarantor Signature Date

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Medical History Questionnaire

Patient Name_____ Date_____

Primary Physician_____ Referring Physician_____

HT_____ WT_____ Is your general health good? ___**Yes** ___**No**

Are you allergic to or have you ever had a reaction to any medication, drug, or anesthetic? _____ ___**Yes** ___**No**
(Novocaine, Xylocaine, Iodine, tapes, lotions, soaps, etc.) Please list:_____

_____

Have you ever had an operation or been hospitalized? ___**Yes** ___ **No**
If so please list and date

_____

Have you ever had rheumatic fever, heart trouble, heart murmurs, heart valve problems, palpitations, irregular heartbeat, chest pains, shortness of breath, angina, or swelling of the ankles?
If yes, circle specific disorder._____ ___**Yes** ___**No**

Have you ever had high blood pressure, anemia, blood disorders, blood clots, strokes, or fainting spells?
If yes, circle specific disorder. _____ ___**Yes** ___**No**

Have you ever had diabetes, arthritis, cancer, thyroid disorders, stomach ulcers, kidney problems, asthma, lung or bronchial disease or any other serious illness?
If yes, circle specific disorder. _____ ___**Yes** ___**No**

Have you ever had problems with hepatitis, IV drug use, HIV/AIDS exposure?
If yes, circle specific disorder _____ ___**Yes** ___**No**

Have you ever had a MRSA infection? _____ ___**Yes** ___**No**

Have you ever had any eye disease or trouble with dryness, soreness, burning, itching, or excessive tearing? **If yes, circle specific disorder**._____ ___**Yes** ___**No**

Have you ever had depression, any psychiatric problems, a nervous breakdown, or been under the care of a psychiatrist? _____ ___**Yes** ___**No**

Do you have a problem with excessive scarring or have you ever formed a keloid after being cut? ___**Yes** ___**No**

Do you or any member of your family bruise easily or have any difficulty with prolonged bleeding When cut or after having a tooth extracted? _____ ___**Yes** ___**No**

Do any diseases run in your family? If so, please list: _____ ___**Yes** ___**No**

_____

Date of your last physical exam: _____Name of M.D._____
Was everything O.K.? ___Yes ___No

Do you smoke, chew tobacco or use nicotine products? If so, how much? _____ ___**Yes** ___**No**
If you quit, when? _____

Do you drink alcohol? If so, how much? _____ ___**Yes** ___**No**

Illicit drugs can cause a dangerous and possible deadly reaction with anesthesia.
Do you use any type of illicit drugs (amphetamines ,barbiturates, opiates, cocaine, marijuana, etc.) ? ___**Yes** ___**No**

Have you ever had a cold sore? ___Yes ____No

Have you ever been prescribed ACCUTANE? ____ Yes _____ No

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Medication list

Please Print Patient Name: _____ Date:_____

Pharmacy:_____ Phone Number:_____

Medication	Reason for taking medication?	Dose	How and How often do you take the medication?	Is drug taken all the time or only as needed?
Example: Lisinopril	*High blood pressure*	*10 mg*	*by Mouth, one pill twice daily*	*All the time*
List all Vitamins, herbal and supplements, other non-prescription drugs such as aspirin, ibuprofen, allergy, etc.				

3455 Lutheran Parkway Suite 220
Wheat Ridge, CO 80033

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PERMISSION TO COMMUNICATE PROTECTED HEALTH INFORMATION

1. **I Grant permission to Cosmetic & Plastic Surgery to disclose health information of the following individual as specified below:**

Patient Name: _____ Date of Birth: _____

2. **I authorize the information to be disclosed as specified below:**

☐ On my voicemail/answering machine at **home** _____(specify phone #)

☐ On my voicemail/answering machine at **work** _____(specify phone #)

☐ On my voicemail on my **cell** _____(specify phone #)

☐ To the following member(s) or other person(s):

_____/_____/_____
Name Relationship Phone Number

_____/_____/_____
Name Relationship Phone Number

☐ Other: **(not able to email results/information)** _____

3. **The type and amount of information to be disclosed is as follows: (Please check appropriate boxes)**

☐ Laboratory results ☐ Medical instructions or advice

☐ X-Ray reports

☐ Prescription drug information

☐ Appointment information, including confirmation/cancelation of appointment and type of appointment.

☐ Do not leave any information on voicemail, attempt to contact directly

*I understand that this may include detailed personal medical information including medical services to be provided, notification that items such as refills are ready for pick-up, as well as any information listed in #3 above.

_____ _____
Signature of Patient or Authorized Person Representative Date
(Please attach applicable legal documentation of authority)

This consent form will expire when revoked in writing by the patient/representative or in the case of a minor, on the date the minor becomes an adult under state law, whichever occurs first.

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NOTICE OF PRIVACY PRACTICES

Exempla Plastic Reconstructive and Aesthetic Surgery
3455 Lutheran Parkway, Suite 220
Wheat Ridge, CO 80033

ACKNOWLEDGEMENT FORM

The attached form describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

I have received the Notice of Privacy Practices (HIPPA packet)

Name: _____

Signature: _____

Date: _____

This consent form will expire when revoked in writing by the patient/representative or in the case of a minor, on the date the minor becomes an adult under state law, whichever occurs first.

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I would like to receive information regarding Cosmetic, Aesthetician and discounts offered by SCL Physicians Plastic, Reconstructive & Aesthetic Surgery.

- o Please send information to my email address provided below:

_____

_____

Patient Name Date

_____

Patient Signature

This information will expire when revoked in writing by the patient

6500 West 104th Avenue Suite 240 * Westminster, CO 80020 * Phone: 303-403-7350 Fax 303-403-7355