

PATIENT REGISTRATION FORM

Current Date (mm/dd/yyyy): _____

PERSONAL INFORMATION

Suffix: Dr. Mrs. Miss Ms. Mr. (Circle One)

First Name: _____

Middle Name: _____

Last Name: _____

DOB: _____ Age: _____

Gender: Female Male

What source of referral led you to Dr. Miles' Office today? _____

Patient ID: _____

Chart No.: _____

SSN: _____

Marital Status: _____

Employed: Yes No

Student: Yes No

CONTACT INFORMATION

Address 1: _____

Address 2: _____

City: _____

State: _____

Zip: _____

E-Mail: _____

Employer/School: _____

Occupation: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Fax: _____

Are there any contact restrictions? Yes No If "Yes", please list: _____

Employer: _____

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

INSURANCE INFORMATION

Do you have health insurance? Y N Secondary insurance? Y N Other? Y N

Primary Health Insurance Company Name: _____

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

Policy Number: _____ Group Number: _____ Phone Number: _____

Do you have a co-payment? Yes No

Is a referral required? Yes No

Name of Insured: _____

Relationship (if not self): _____

DOB: _____

SSN: _____

Employer: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship to Patient: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

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

Patient/Guardian Signature: _____

North Charlotte Plastic & Reconstructive Surgery, P.A.
16455 Statesville Road, Suite 490, Huntersville, NC 28078 (704)896-5556

Health History Form

Name: _____ Today's date: _____
Last First Middle

Height: _____ Weight: _____ Date of Birth: _____ Age _____
dd/mm/yyyy

Reason for Consultation: _____

Current or past medical conditions: _____

Previous Plastic Surgery Procedures: _____

Other Surgery Procedures: _____

Current Medications and Dose/Frequency: _____

Current Herbal Medication/Supplements: _____

Drug Allergies (describe reaction) : _____

Social History:

Do you smoke? Yes No How long and how much? _____
Do you drink alcohol? Yes No How long and how much? _____
Do you use illicit drugs? Yes No List: _____

Physician Information:

Primary Physician: _____ Phone number: _____

Pharmacy: _____ Phone number: _____

Please describe any additional information relevant to your medical history that you feel might be important.

Mark any symptoms or medical conditions you have experienced.

x		x		x	
	General		Abdomen		Genitourinary
	Weight loss/gain		Frequent abdominal pain		Kidney stones
	Frequent or Recent Fever/Chills		Heartburn/reflux/ulcer		Difficulty urinating
	Fatigue		Frequent nausea/vomiting		Prostate problems (men)
	Insomnia		Frequent diarrhea		Sexually transmitted disease
	Chronic pain		Frequent constipation		Urinary incontinence
	Motion sickness		Liver problems		
	Prolonged/frequent illness		Gall bladder problems		Hematological
			Jaundice (yellowing)/Liver problems		Easy bruising
	Head and Neck		Abdominal malignancy		Hematoma
	Frequent headaches/migraines		Rectal disease		Anemia
	Facial trauma		Hernia		HIV/AIDS
	Facial fractures				Hepatitis
	Neck Injury		Lungs		Bleeding disorder
	Limited neck movement		Abnormal chest x-ray		Blood transfusion
	Jaw pain		Shortness of breath		Use of blood thinners
	Decreased vision		Asthma		
	Dry eyes		Emphysema		Skin
	Glaucoma		Pneumonia		Keloids/hypertrophic scarring
	Cataracts		Tuberculosis		Skin cancer
	Decreased hearing		Collapsed lung		Poor wound healing
	Balance problems		Pulmonary embolism		Sun damage/sunburns
	Sore throat		Lung cancer		Tanning bed history
	Hoarseness		Chronic cough		Acne
	Sinus problems/sinusitis				Latex sensitivity
	Snoring/Sleep apnea		Musculoskeletal		Tape sensitivity
	Nose bleeds		Arthritis		Alopecia
	Neck masses/lumps		Poor circulation		Psoriasis
	Head and neck cancer		Leg cramps/"restless legs"		Tattoos
	Facial paralysis/Bell's Palsy		Varicose veins		Hydradenitis
			Amputation/deformities		
	Heart		Phlebitis/blood clots		
	High blood pressure		Frequent back pain		
	Low blood pressure		Fibromyalgia		
	Heart disease				
	Heart murmur		Neurological		Females only:
	Heart palpitations		Seizures		Family history of breast cancer
	Irregular heartbeat		Stroke		Breast biopsy
	Heart attack		Brain aneurysm		Breast cancer
	Chest pain/Angina		Fainting/dizziness		Breast pain
	Heart valve problem		Paralysis		Nipple discharge
	Artificial heart valve		Amnesia		Fibrocystic breast disease
	Abnormal stress test				Skin/nipple changes
	Cardiac catheterization		Psychiatric		Abnormal mammogram
	Stent placement		Depression		
	Pacemaker		Anxiety		Irregular menses
			Fear of needles		Abnormal pap smear
	Endocrine		Body dysmorphic disorder		Dyspareunia (painful intercourse)
	Diabetes		Panic attacks		
	Thyroid problems		Attempted suicide		Pregnancy
	Steroid use		Treatment for addiction		Breastfeeding

Please explain any positive responses marked above.

Plastic Surgery History

8	Procedure	Date	Complications (if any)
	Breast Augmentation		
	Breast lift alone		
	Breast lift with augmentation		
	Breast reduction		
	Gynecomastia surgery (<i>men</i>)		
	Facelift		
	Browlift		
	Eyelid surgery		
	Otoplasty (ear surgery)		
	Rhinoplasty (nose surgery)		
	Chin augmentation		
	Lip enhancement		
	Hair transplantation		
	Botox ®		
	Dermal fillers		
	Fat injections to face		
	Skin laser treatment		
	Dermabrasion		
	Microdermabrasion		
	Chemical peel		
	Laser hair removal		
	Liposuction		
	Abdominoplasty (tummy tuck)		
	Buttock augmentation		
	Body lift		
	Arm lift		
	Thigh lift		
	Vaginal rejuvenation		
	Reconstruction of congenital malformation		
	Breast reconstruction:		
	TRAM		
	Latissimus dorsi		
	Tissue expander/implant		
	Other		
	Head and neck reconstruction		
	Abdominal reconstruction		
	Reconstruction of an extremity		
	Hand surgery		
	Chronic wound treatment		
	Skin graft		
	Secondary /revision plastic surgery		
	<i>If yes, please explain:</i>		
	Other procedures (please list)		

North Charlotte Plastic & Reconstructive Surgery, P.A.

FINANCIAL POLICY

We believe that part of a good health care practice is to establish and communicate a financial policy to our patients. An informed and responsible patient should never have a credit problem with our practice.

PAYMENT is expected on the same day of each visit prior to the physician encounter. We accept cash, checks, debit card, Visa, MasterCard, American Express.

PAYMENT will include any unmet deductible, co-insurance, co-payment amount, outstanding balance, cosmetic or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause or waiting period, payment in full is expected at the time of your visit. A consultation fee is assessed to all cosmetic consultations. Please be prepared to pay this on the day of your visit.

We are a participating provider for most insurance carriers. We will file all primary and secondary insurance claims for you. We do NOT file with third parties; however, we will provide you with the information for you to do so. Please remember that insurance is a contract between the patient and the insurance company and ultimately you are responsible for payment in full to our office.

We do offer financing through Care Credit. Applications are available in our office or on the web at www.carecredit.com. Financial arrangements must be made prior to services being rendered.

LAB/HOSPITAL CHARGES: Any service(s) provided by a lab or hospital is a contract between you and that lab or hospital. Any dispute with that lab or hospital should be handled with that facility and is not the responsibility of our practice. It is your responsibility to know which procedures your insurance will and will not cover at these facilities and to request an Explanation of Benefits (EOB) from your insurance carrier.

RETURNED CHECKS will incur a \$75.00 service charge. You will be asked to bring cash or money order to cover the amount of the check plus the service charge.

DISABILITY FORMS, INSURANCE FORMS, COPIES OF MEDICAL RECORDS, ETC., require office staff time and time away from patient care for the physicians. Therefore we require 3 business days to complete the forms and requests. A processing fee may be assessed for these services.

COLLECTIONS: Patients, whose accounts have been turned over to our collection agency and/or attorney, will be responsible for the account balance and all costs associated with collection, including but not limited to, attorney fees.

CANCELING COSMETIC SURGERY: If you choose to cancel your surgery without rescheduling, all but your 10% deposit will be refunded within 30 days.

AUTHORIZATION / FINANCIAL INFORMATION

I hereby authorize the release of medical information to my insurance carriers concerning my and/or my dependent's medical condition and treatment for the purpose of claim payment.

I assign all insurance carriers' payments, for medical services rendered to myself and/or dependents to North Charlotte Plastic & Reconstructive Surgery, P.A.

I agree that if my insurance carrier sends payment to me for medical services rendered instead of North Charlotte Plastic & Reconstructive Surgery, P.A., I will immediately pay the amount due to North Charlotte Plastic & Reconstructive Surgery, P.A.

I agree it is my responsibility to understand my insurance benefits and to notify North Charlotte Plastic & Reconstructive Surgery, P.A., immediately of any changes to my insurance coverage.

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.

Patient/Guardian Signature

Date

Witness Signature

Date

