PANHANDLE PLASTIC SURGERY

NEW PATIENT INFORMATION

(Cosmetic patients do NOT need to fill out Insurance Fields)

LAST NAME:_____ FIRST:_____ MI:_____

MAILING ADDRESS: _____ CITY:_____ZIP:_____

HOME PHONE: _____ CELL PHONE: _____

DOB:_____/ _____/ _____ SS#: _____

EMAIL:_____ MARITAL STATUS:_____

OCDUPATION/ EMPLOYER: _____

EMERGENCY CONTACT:_____ PHONE:_____

RELATIONSHIP TO PATIENT: _____ PATIENT RACE: _____

ETHNICITY: HISPANIC: _____ NON-HISPANIC: _____ DECLINED TO SPECIFY: _____

HOW DID YOU HEAR ABOUT US: _____

PRIMARY CARE PHYSICIAN: _____

PHARMACY (NAME AND PHONE NUMBER): _____

INSURANCE INFORMATION

PRIMARY INSURANCE:	
ID #:	
GROUP #:	
SUBSCRIBER NAME:	
SUBSCRIBER	**DOB:** ____/___/____ **SOCIAL SECURITY #:** ____-___-____
SUBSCRIBER EMPLOYER:	
SECONDARY INSURANCE:	
ID#:	
GROUP #:	
SUBSCRIBER NAME:	
SUBSCRIBER	**DOB:** ____/___/____ **SOCIAL SECURITY #:** ____-___-____
SUBSCRIBER EMPLOYER:	

_____ _____

SIGNATURE **DATE**

PATIENT NAME: _____ **DRUG ALLERGIES:** _____

_____

Reason for Visit: _____ Age at !st Pregnancy: _____

Height: _____ Weight: _____

Are you or could you possibly be pregnant? _____ Number of Children: _____ #Breast Fed: _____

Current Medications/ dosages taken in last month: _____

_____

_____

_____

Previous Surgeries/ Dates: _____

_____

_____

_____

SMOKING HISTORY: **DO YOU SMOKE?** _____ **HOW MANY PACKS/DAY?** _____

IF SO HOW LONG HAVE YOU SMOKED? _____ **FORMER SMOKERS HOW LONG AGO DID YOU QUIT?** _____

ALCOHOL HISTORY: **DO YOU DRINK? YES:**_____ **NO:**_____

LESS THAN 6 DRINKS/ WEEK?_____ **6 OR MORE DRINKS A WEEK?** _____

BREAST HISTORY (IF APPLICABLE): **IF YOU HAVE HAD BREAST SURGERY WHAT TYPE?** _____

DO YOU HAVE BREAST CANCER IN YOUR FAMILY? _____ **IF SO, WHO AND WHAT AGE?** _____

DATE OF LAST MAMMOGRAM: _____ **WHERE:** _____

ANY CONCERNS/ ABNORMALITIES? _____

AGE AT FIRST MENSTRUAL PERIOD: _____ **MENOPAUSE:** **YES/ NO** **IF YES, WHAT AGE:** _____

PERSONAL MEDICAL HISTORY: HAVE YOU EVER HAD OR DO YOU NOW HAVE: CHECK YES AND NO

SHORTNESS OF BREATH	YES	NO	EXCESSIVE SCARRING/ KELOID	YES	NO
ASTHMA	YES	NO	VOMITING BLOOD/ BLACK STOOLS	YES	NO
CHRONIC BRONCHITIS	YES	NO	RECENT WEIGHT GAIN/ RECENT WEIGHT LOSS	YES	NO
FREQUENT COLD/ COUGH	YES	NO	HEMORRHOIDS	YES	NO
HEART DISEASE	YES	NO	HERNIA (GROIN/ ABDOMINAL)	YES	NO
BLOOD PRESSURE - HIGH/ LOW	YES	NO	KIDNEY TROUBLE OR NEPHRITIS	YES	NO
HEART VALVE PROBLEMS/ MURMURS	YES	NO	PAINFUL OR BLOODY URNINATION	YES	NO
BREAST PROBLEMS	YES	NO	USE OF HORMONES/TYPE	YES	NO
BACK PAIN	YES	NO	VARICOSE VEINS	YES	NO
ANKLE SWELLING	YES	NO	BLOOD CLOTS	YES	NO
EASY BRUISING	YES	NO	RADIATION THERAPY	YES	NO
EXCESSIVE BLEEDING	YES	NO	EPILEPSY/ OR SEIZURES	YES	NO
ANEMIA OR BLOOD DISEASE	YES	NO	EMOTIONAL/ PSYCHIATRIC PROBLEMS	YES	NO
THYROID DISEASE	YES	NO	FREQUENT OF SEVERE HEADACHES	YES	NO
RASH	YES	NO	AIDS OR HIV	YES	NO
DIABETES	YES	NO	FACIAL PARALYSIS OR NUMBNESS	YES	NO
SKIN CANCER	YES	NO	LIMITED ACTIVITY	YES	NO
ARTHRITIS/ JOINT PROBLEMS	YES	NO	ANESTHESIA PROBLEMS	YES	NO
CHRONIC DIARRHEA/ BOWEL TROUBLE	YES	NO	HERPES/ OR FEVER BLISTERS	YES	NO
HEPATITIS/ JAUNDICE/ LIVER TROUBLE	YES	NO	EATING DISORDER	YES	NO

PLEASE LIST ANY OTHER MEDICAL CONDITION:

_____

_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT
FINANCIAL CONSENT

PANHANDLE PLASTIC SURGERY
ELISE MAY, MD
1301 S COULTER STE 201
AMARILLO, TX 79106

I understand that, under the Health Insurance Portability & Accountability Act of 1966 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that his information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Panhandle Plastic Surgery has the right to change its Notice of Privacy Practices from time to time and that I may contact them at any time at the above address to obtain a copy of the current Notice of Privacy Practices.

I understand that I may request in writing restrictions to the use/disclosure of my private information. I also understand that Panhandle Practice Surgery is **NOT** required to agree to my requested restrictions, but if agreed to, then Panhandle Plastic Surgery is bound to abide to such restrictions.

CONFIDENTIAL COMMUNICATIONS

I request that all communications to me (by telephone, mail or otherwise) by Panhandle Plastic Surgery, and/or its staff be handled in the following manner:

Email: _____ Phone: _____
If you are unavailable at this number, may we leave a voicemail? YES_____ NO_____

Do we have permission to disclose your health information with another person?
YES_____ NO _____
If yes, Please Name: _____
_____

FINANCIAL CONSENT

I have read the Financial Policy and agree to its terms.

_____ _____
PATIENT SIGNATURE **DATE:**

PANHANDLE PLASTIC SURGERY
COVID-19 RISK INFORMED CONSENT

I _____understand that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact: and, as a result, federal and state health agencies recommend social distancing. I recognize that Dr Elise May and all the staff at Panhandle Plastic Surgery and the performing facility are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for Dr Elise May and all the staff at Panhandle Practice Surgery and the performing facility to proceed with the same.

I understand that, even if I have been tested for COVID-19 and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID-19 after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.

I have been given the option to defer my treatment/procedure/surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery.

Patient Initials _____

INFORMED CONSENT FOR COVID-19 RISK

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE TREATMENT/PROCEDURE/SURGERY.

NAME: _____ **DATE:** _____

WITNESS: _____ **DATE:** _____

I have been offered a copy of this consent form: **Patient Initials** _____