Piedmont Plastic Surgery, PA

Patient's Full Legal Name: _____ Date of Birth: _____Age_____

Social Security Number: _____ Sex: Male____ Female ____

Marital Status (please circle one): SINGLE MARRIED WIDOWED DIVORCED SEPARATED

We are now required to collect Race, Ethnicity and Language. If you prefer not to report that information, you may choose Refused to Report/Unreported.

(Please Check ONE in EACH CATEGORY that applies)

RACE		ETHNICITY	PREFERRED LANGUAGE	
☐ White	☐ More Than One	☐ Hispanic or Latino	☐ English	☐ Hindi
☐ Black or African American	☐ Native Hawaiian	☐ Not Hispanic or Latino	☐ Spanish	☐ Vietnamese
☐ Asian	☐ Other Pacific Islander	☐ Refused to Report/Unreported	☐ Urdu	
☐ American Indian or Alaskan Native	☐ Undefined	☐ Undefined	☐ Refused to Report/Unreported	
☐ Refused to Report/Unreported			☐ Other	

Employer's Name: _____

Employer's Address: _____

Employer's Telephone Number: _____

PATIENT ADDRESS INFORMATION

Address: _____
Street City State Zip Code

Email address: _____

Home Phone: ( ) _____ Work Phone: ( )_____ext _____

Cell Phone: ( ) _____ Spouse Name:_____ DOB:_____

Primary Care Physician_____ Referring Provider Name:_____

HOW DID YOU HEAR ABOUT US? (Please Check all that apply)

☐Family/Friend	☐ Online Yellow Pages	☐ Employer Website	☐ Internet Search	☐ Billboard
☐Hospital	☐ Newspaper	☐ Mailer	☐ Radio	☐ Doctor
☐Seminar-Special Event	☐ Sports Team Support	☐ TV	☐ Worker's Comp	☐ Other: _____
☐Existing Patient	☐ Self Referral			☐ Other _____

Piedmont Plastic Surgery, PA

PLEASE HAVE YOUR INSURANCE CARD(S) AND PHOTO ID READY TO BE COPIED

GROUP INSURANCE INFORMATION

Primary Insurance:_____ Member ID:_____

Policyholder Name: _____ Policyholder Date of Birth:_____

Group #: _____Patient's Relation to Policyholder: (CIRCLE ONE) Self Wife Husband Child Parent Other

Secondary Insurance:_____ Member ID:_____

Policyholder Name: _____Policyholder Date of Birth: _____

Group #: _____Patient's Relation to Subscriber: (CIRCLE ONE) Self Wife Husband Child Parent Other

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____Relationship: _____

Home Phone: ( )_____ Work: ( )_____ Cell: ( ) _____

IF PATIENT IS UNDER 18 YEARS OLD, PLEASE COMPLETE PARENT/GUARDIAN/GUARANTOR SECTION BELOW

Parent/Guardian/Guarantor Name: _____

Address:_____

(if different from above) Street City State Zip Code

Home Phone: ( ) _____ Work: ( )_____ Cell: ( ) _____

Social Security #: _____ Date of Birth: _____ Sex: M _____ F _____

Marital Status: (CIRCLE ONE) Single Married Widowed Divorced Separated

---

The undersigned makes the following acknowledgments and agreements regarding treatment to be provided to the patient whose name appears above:

1 – **Consent to treatment: I** consent to any medical or surgical treatment rendered to the patient under general or special instructions of the physician. I certify that no guarantee of assurance has been made to me as to the results which may be obtained.

2 – **Release of medical information: I** authorize the release of any medical or other information from this provider and other providers necessary to process a health insurance claim or to provide treatment.

3 – **Assignment of benefits: I** authorize payment of medical benefits to Piedmont Plastic Surgery, PA

I certify that the information given at the time of registration is correct. I understand that I will be financially responsible for all charges in full at the time I am given treatment unless otherwise discussed before I am seen. I understand I am financially responsible to Piedmont Plastic Surgery PA for charges not covered by insurance.

_____ _____

Signature of Patient, Guardian or Legal Representative **Date**

Piedmont Plastic Surgery, PA

Virgil V. Willard, II, M.D.

1011 N. Lindsay St., Suite 202, High Point, NC 27262 • (336) 886-1667 • Fax: (336) 886-5536

HISTORY FORM

Date: _____ Name: _____ Date of Birth: _____

Ht: _____ Weight: _____lbs. Primary Care and/orMedical Doctor: _____

Reason for Visit: _____

List Operations with Dates: _____

_____

Any Recent Problems With:

Lungs	☐ YES ☐ NO	Heart	☐ YES ☐ NO
High Blood Pressure	☐ YES ☐ NO	Stroke	☐ YES ☐ NO
Seizures	☐ YES ☐ NO	Cancer	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO	Urination	☐ YES ☐ NO
Stomach or Intestines	☐ YES ☐ NO	Musculoskeletal	☐ YES ☐ NO
Eyes, Ears, Throat	☐ YES ☐ NO	Enlarged Lymph Nodes	☐ YES ☐ NO
Bleed or Bruise Easily	☐ YES ☐ NO	Skin	☐ YES ☐ NO
Breasts	☐ YES ☐ NO		
Tuberculosis (TB)	☐ YES ☐ NO	Resistant infection (MRSA, VRE)	☐ YES ☐ NO
Have you ever received blood	☐ YES ☐ NO	If so, When? _____	

Date of last Tetanus Shot: _____

For Women:

Bra size _____inches _____cup

Number of children _____

If you answered "YES" to any of the above questions, please provide details:

_____

_____

_____

_____

Current Medications (including vitamins and herbs): _____

_____

Drug Allergies: _____ Circle Reaction: rash, nausea, itching, other _____

_____ _____

Habits: Cigarettes _____ packs/day _____ Alcohol per week: _____

If you do not smoke, did you ever? Y N If yes, how many years? _____ Year you quit _____

Have you ever used other (recreational) drugs? Y N

Please list drug use, recreational/substance abuse: _____

List diseases that run in the family: _____

PIEDMONT PLASTIC SURGERY, PA

Notice of Privacy Practices Receipt Acknowledgement

I have been presented with a copy of Piedmont Plastic Surgery's Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice.

_____ _____ _____

Patient Name Date of Birth Signature of Patient or Guardian

Date of Receipt_____

(1) Please list the family members and/or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment & health care operations):

Name_____ Phone Number_____

Name_____ Phone Number_____

Name_____ Phone Number_____

(2) Please list the family members and/or other persons, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name_____ Phone Number_____

Name_____ Phone Number_____

Name_____ Phone Number_____

(3) Please list the telephone number(s) where you want to receive calls about your appointments, lab & x-ray results, or other health care information:

_____ _____

(4) Can confidential messages (i.e. appointment information) be left on your answering machine? ___Yes ___No

(5) Can we send you the following information electronically?

Information about your medical conditions _____Yes _____No

Information about health-related benefits or services that may be of interest to you

_____Yes _____No

Information about potential treatment options or alternatives

_____Yes _____No

Appointment reminders _____Yes _____No

Please note that if individuals other than you have access to the contents of this electronic mail address, those individuals could also have access to any information we send to you at that address. Piedmont Plastic Surgery will not be responsible if such individuals access information that is sent to the electronic mail address you provide.

Please note that while we may ask you from time to time if there have been any changes to this information, it is your responsibility to update this information as needed.

Internal Use Only

If patient or patient's representative refuses to sign acknowledgement of receipt of Notice, please document the date and time the Notice was presented to patient and sign below: Presented on (date)_____ Name/Title_____

Revklh102014