Date ___________________

GENERAL INFORMATION

Name (first, middle, last) ____ Gender _____ DOB ___-___-___ Age ___

Mailing Address ____ City ________________ State ______ Zip_____________

Street Address (if different than above) _________________________________ Email ______________________________

Home Phone (______) ___________________________ Cell Phone (______) ___________________________

Social Security # _________________________________ Marital Status Married ____ Single ____ Divorced ____

Who referred you to the office? (Doctor / Friend / Other) ____

EMPLOYMENT

Patient's Employer ____ Work Phone (_____) ________________________

Patient Occupation ____

Spouse Name (or parents if minor) ____

Spouse Employer ____ Work Phone (_____) _________________________

INSURANCE

Primary Insurance ____ Policy Holder DOB ____________________________

Primary Insurance Policy Holder Name _________________________________ Policy Holder SS# _____________________

Secondary Insurance ____ Policy Holder DOB ____________________________

Secondary Insurance Policy Holder Name _______________________________ Policy Holder SS# _____________________

EMERGENCY CONTACT

Emergency Contact (other than spouse) __________________________________ Relationship to Patient ____________________

Phone number (_____) ______________________

CONTACTING YOU

There may be occasions in which our office needs to contact you concerning your appointment, diagnostic testing results or billing problems or any other situation relating to your visit at our office. Please read and answer the following questions:

East Tennessee Plastic Surgery has permission to contact the numbers checked below as well send and/ or receive information such as test results appointments, pictures, and other information pertaining to me or to anyone answering the telephone or on an answering machine

Home ________ Cell ________ Text ________ Work ________

East Tennessee Plastic Surgery has my permission to email me about any information pertaining to my visits and/or special services or promotions currently being offered at the office.

Yes ________ No ________ Email ______________________________

PRIVACY POLICY

I have had the opportunity to review the privacy policy and have been offered a written copy of this policy.

Signature ____ Date ____

MEDICAL HISTORY

Primary Care Physician ____ Office Phone Number (_____) _______________

Other Physicians you have seen in the last 3 years: ____

Medical problems: ____

Current medications – prescription and nonprescription with doses: ____

____

Do you take Aspirin? Yes / No   Prescribing Physician of Aspirin __________________________________

Do you take Turmeric? Yes / No   Flax Seed? Yes / No   Other supplements: ___________________________

Fish Oil? Yes / No   Vitamin E? Yes / No   ____

Allergies to medications: ☐ None or list ____

Are you allergic to latex? Yes / No   Do you use nicotine? Yes / No   Do you drink alcohol? Yes / No

SURGICAL HISTORY

Prior surgeries (date): ____

GENERAL AUTHORIZATION – ALL PATIENTS PLEASE READ AND SIGN

ASSUMPTION OF RESPONSIBILITY: the undersigned, whether he/she signs as an agent or as a patient, agrees to pay East Tennessee Plastic Surgery all fees for services rendered. This includes services rendered at our office and practice/surgeon fees for services rendered at an outside facility. Should the account be referred for collection, the undersigned shall pay all reasonable fees and collection expenses. All delinquent accounts to bear interest at the legal rate. It is understood that bills are payable within 30 days of receipt. I have read and understand the above information.

Signature ____ Date ___________________

ALL INSURANCE PATIENTS – PLEASE READ AND SIGN

ASSIGNMENT OF INSURANCE BENEFITS: I/We hereby guarantee payment of all charges incurred for the account of the above said patient from the date of first treatment until discharge or termination of treatment. I/We hereby assign all insurance benefits to be paid to East Tennessee Plastic Surgery, P.C. I understand that I am responsible for any deductible and co-insurance. I authorize the release of my medical records to the insurance company for the determination of benefits. All non-covered expenses will be considered cosmetic and applicable policies will apply. I have read and understand the above information.

Signature ____ Date _____________________

ALL INSURANCE AND COSMETIC PATIENTS – PLEASE READ AND SIGN

A **$500 NONREFUNDABLE** deposit is required to schedule surgery. If you cancel surgery with less than two weeks notice, 25% of the price of the surgery or the deposit of $500 (whichever is greater) will be forfeited. If you cancel surgery with two weeks or more notice, the deposit is transferrable for twelve months. After that time, it is forfeited. The remaining surgery balance is due two weeks before your surgery. We accept cash, checks, and all major credit cards. We also accept Care Credit. Any refunds on credit cards will be assessed a 10% refund fee. **East Tennessee Plastic Surgery** will **NOT** file health insurance or provide information for the patient to file health insurance on any procedure or surgery that is paid for as cosmetic by the patient. I have read and understand the above information regarding payments to East Tennessee Plastic Surgery.

Signature ____ Date _____________________

MEDICARE and MEDICARE HMO PATIENTS – PLEASE READ AND SIGN

I request that payment of authorized Medicare benefits be made to East Tennessee Plastic Surgery for any covered services furnished to me by a provider at ETPS. I authorize the release of my medical records to Medicare for benefits to be determined. I understand that I am responsible for my deductible and 20% of the allowable Medicare charges (if not covered by my secondary insurance carrier or if I do not have secondary insurance). All non-covered procedures will be considered cosmetic and applicable policies will apply. I also request that payment of authorized Medigap benefits be made on my behalf to above listed provider and authorize release of medical information required to determine.

Signature ____ Date ______________________