Please Help Us!

We would like to know how you heard about

LANDON PLASTIC SURGERY.

Your Name: _____Date:_____

PLEASE SELECT ALL THAT APPLY:

☐ **Friend/Family* Please write name so that we can thank your referral**
Name: _____

☐ **Magazine:** _____
Neighborhood News: _____

☐ **Radio:**_____

☐ **Internet: Website Name:** _____

☐ **Billboard- Location:** _____

☐ **Drs. Office- Drs. Name:** _____

☐ **Event- Name:** _____

☐ **Yellow Pages:**_____

Landon Plastic Surgery
PATIENT INFORMATION FORM

Name _____ Date _____
(Last, First, MI)

Reason for Visit _____

Date of Birth _____ Age _____

Marital Status: Single Married Divorced Widowed

Address _____ City _____ State ____ Zip _____

Home Phone _____

Alternate/Cell Phone_____

Spouse's Name _____

Emergency Contact _____ Relationship _____

Emergency contact # _____ Alternate # _____

I authorize my healthcare provider to send information to me, either electronically or through a mail service, about products or services the practice may now or in the future provide that may be of interest to me including e-mail updates and specials about Landon Plastic Surgery.
If so, Please write your email here:_____

Signature:_____

If patient is a Minor (under 18 years of age)

Parent's Name _____
(Last, First, MI)

Phone _____ Alternate phone # _____

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PATIENT INFORMATION

Date _____ **Patient Name** _____ **Female/Male (circle)**

Last First Middle

Age _____ **Date of Birth** _____ **Height** _____ **Weight** _____ **Occupation** _____

Reason for your visit _____

PAST MEDICAL CONDITIONS (mark all that apply)

___ No past medical history
___ AIDS
___ Alcoholism
___ Anemia
___ Anesthesia Problems
___ Autoimmune Disorder
___ Arthritis
___ Asthma
___ Bleeding Disorder
___ Breast Cancer
___ Cancer
___ Chest Pain/tightness
___ Anxiety
___ Depression
___ Diabetes
If yes: Insulin Y / N
___ Heart Disease
___ Heart Attack Date _____
___ Hepatitis
___ Heart murmur
___ Healing Problems
___ High Blood Pressure
___ High Cholesterol
___ HIV Positive
___ Inflammatory Bowel Disease
___ Kidney Disease
___ Liver Disease
___ Lung Disease
___ Malignancy
___ Pacemaker
___ Post Radiation Therapy
___ Psychiatric Care
___ Skin Cancer/ Melanoma
___ Stroke
___ Substance Abuse
___ Thyroid Problem
___ Tuberculosis
___ Transfusion
If so, type and date of last transfusion: _____

FEMALES ONLY:
___ Fibrocystic Breasts
___ BRCA Gene positive
___ Going through Menopause
___ Ovarian Cancer
___ Last Mammogram
Location:_____
Date: _____
Normal: Y/N
___ # Pregnancies _____
___ # Live births _____
___ Ages of Children _____
___ Plan becoming Pregnant?
Yes_____
No_____

HAVE YOU HAD IN THE LAST MONTH OR DO YOU PRESENTLY HAVE:

___ CHF (Congestive Heart Failure)
___ Serious infection or sepsis
___ Central Venous Access (IV Access)
___ Elective Hip or knee Replacement
___ Hip, pelvis, or leg fracture
___ Surgery (explain below)
___ History of unexplained stillborn infant, 3 or more spontaneous abortions, premature birth with toxemia or growth restricted infant
___ Serious Trauma
___ Spinal Cord Injury/paralysis
___ Non - removable plaster cast or mold
___ Pregnancy or postpartum
___ Visible Varicose Veins
___ Have swollen legs
___ Confined to bed for 72 hrs or more

SURGICAL HISTORY: list any surgeries/hospitalizations with year

SURGERY/HOSPITALIZATION (include cosmetic procedures) **YEAR**

_____
_____
_____
_____
_____
_____
_____

HEALTH HISTORY

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CURRENT MEDICATIONS (include Vitamins & Supplements)

ARE YOU TAKING?

ASPIRIN? Y / N ORAL CONTRACEPTIVES? Y / N CHEMOTHERAPY? Y / N

INSULIN? Y / N HORMONE REPLACEMENT THERAPY? Y / N

SUPPLEMENTS / VITAMINS? Y / N

Drug name / Supplements Dose Frequency

_____

_____

_____

_____

_____

ALLERGIES:

Please list all medication / Substance Allergies

_____

_____

_____

_____

_____

LATEX ? YES_____ NO_____

SOCIAL HISTORY

Do you smoke? Yes ____ No _____ Yes/How much? _____ No/Date quit: _____

Do you drink alcohol? Yes ____ No _____ Drinks per week: _____

Substance Abuse? Yes ____ No _____ Drug: _____ How often? _____

FAMILY HISTORY

Do you have a family history of trouble with anesthesia? Yes_____ No_____

Do you have a family history of easy bleeding or clotting? Yes_____ No_____

Family history of positive blood test for increased risk of clotting (Factor V Leiden) Yes_____ No_____

PHARMACY INFORMATION

Please provide us with your Pharmacy Name: _____ Pharmacy # _____

I CERTIFY THAT I HAVE DISCLOSED MY MEDICAL HISTORY TO THE BEST OF MY KNOWLEDGE.

_____ _____

Patient Signature **Date**

_____

Print Name

Landon Plastic Surgery

RIGHT TO SHARE INFORMATION WITH FAMILY AND FRIENDS

Landon Plastic Surgery reserves the right to communicate protected health infor-mation (PHI) with family or friends when it is deemed in the best interest of the patient as described in the Notice of privacy. In order to have your PHI shared in other circumstances with the members of your family or friends, please list those individuals that we are authorized to release information.

_____ _____

_____ _____

_____ _____ _____

Patient Signature **Print Name** **Date**

Landon Plastic Surgery DOES NOT contract with any private medical insurance companies, including but not limited to Medicare and/or Medicaid.

Your signature below acknowledges your understanding that services rendered are strictly fee for service. Please be advised that we are unable to provide ANY information to insurance companies.

_____ _____ _____

Patient Signature **Print Name** **Date**

Please be advised that I authorize Landon Plastic Surgery or whomever they designate to represent them to transmit any medical data over the computer lines or telephone lines by means of cell phone (texting) or fax lines. I understand that it is possible that such transmission of this information could inadvertently wind up in the wrong hands. However, the timely transmission of this information is im-portant enough for me to accept the risk.

_____ _____ _____

Patient Signature **Print Name** **Date**

To disclose, as may be necessary, your health information (including HIV +/AIDS status, drug/alcohol abuse/dependency notes and qualified mental health notes) to other health care providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payemnt and/or healthcare.

_____ _____ _____

Patient Signature Print Name Date

Landon Plastic Surgery

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give consent to Landon Plastic Surgery and all health care providers furnishing care within the practice to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Please be advised that our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by contacting our Privacy Officer at 727-376-3999.

You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the above address and will be effective when said notification is received. Your revocation will not be effective to the extent that we or others have acted in reliance upon the consent.
I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

_____	_____	_____
Patient Signature	**Print Name**	**Date**

If you are signing as patient's representative, print your name: _____
Describe your relationship to the patient: _____