



PATIENT INFORMATION: (please print)

First Name: _____ Middle: _____ Last: _____

Primary Address: _____
street apt/unit no. City State Zip

Secondary Address: _____
street apt/unit no. City State Zip

Home Phone: _____ May we leave a message for you at home? **Y N**

Work Phone: _____ May we call you at work? **Y N**

Cell Phone: _____ May we leave a message for you on your cell? **Y N**

E-Mail: _____ May we email you special offers/newsletters? **Y N**

Employment: _____ (NOTE: We never share your email)

Date of Birth: _____ Age: _____ Sex: **M F** Martial Status: _____ Name of Spouse: _____

Social Security No: _____ Drivers License No. & State: _____

Emergency Contact: _____ Relation: _____ Phone Number: _____

RESPONSIBLE PARTY INFORMATION:

Responsible Party: _____ Relationship to Patient: _____

Responsible Party Phone: _____ Alternate Number: _____

Is This Work Related or a Motor Vehicle Accident? **Y N**

INSURANCE INFORMATION: (please present insurance card to receptionist after completing below)

PRIMARY insurance company's name: _____ Phone #: _____

Insurance Address: _____ SS# _____

Name of policyholder/insured: _____ Date of Birth: _____ Relationship to patient: _____

ID# _____ Group #: _____ Employer Name: _____

Secondary insurance company's name: _____ Phone #: _____

Insurance Address: _____ SS# _____

Name of policyholder/insured: _____ Date of Birth: _____ Relationship to patient: _____

ID# _____ Group #: _____ Employer Name: _____

REFERRAL INFORMATION:

Name of Referring Physician: _____ Other referral form: _____

Primary Care Physician: _____

Physician Office Address _____ Phone Number: _____

Reason for visit? _____ **Date of onset?** _____

Assignment of Benefits-Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Monarch Plastic Surgery, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I agree to be photographed by this healthcare provider for the purpose of medical record requirements, medical insurance authorization and education. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature

Date

Responsible Party (if minor)

Date



HEALTH HISTORY

Name: _____

Do you have any known Allergies?

Yes No

If yes please list:

Medications

List Medications you are currently taking, prescriptions, and over the counter medications. Also, list vitamins, dietary supplements, anti-inflammatories and aspirin:

CONDITIONS/SYMPTOMS: (past or current)

- | | |
|---|--|
| <input type="checkbox"/> Alcoholism or Chemical Dependency | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Anemia or Bleeding Disorders | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Breast Disease or Abnormal Mammogram | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Depression or Psychiatric Care | <input type="checkbox"/> Lung Disease or Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous System Disorder |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Herpes | |

HOSPITALIZATIONS/OPERATIONS/SERIOUS ILLNESS:

Year	Hospital	Reason and Outcome

FAMILY HISTORY: (please list any serious conditions below)

Disease	Relationship to you

HEALTH HABITS:

Check which substances you use and frequency.

- Drugs/Alcohol _____
- Tobacco _____
- Caffeine _____

ARM OR HAND CONCERNS ONLY:

Right or Left Handed? _____

Injured Hand? Right Left

FOR WOMEN ONLY:

Height _____ Weight _____

Date of last Mammogram _____ Results: _____

Are you pregnant or any chance you could be pregnant? _____

Number of pregnancies: _____ Date of last delivery: _____

MONARCH PLASTIC SURGERY

AESTHETIC * PLASTIC * RECONSTRUCTIVE * HAND * MICROSURGERY

DANIEL P. BORTNICK M.D., F.A.C.S.

RICHARD J. BENE M.D., F.A.C.S.

REGINA M. NOUHAN M.D., F.A.C.S.

JEFFREY R. DILLOW M.D., F.A.C.S.

KEITH R. HODGE, M.D., F.A.C.S.

PAUL J. LEAHY, M.D.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I do hereby authorize Monarch Plastic Surgery, hereinafter referred to as "Medical Provider", to furnish my insurance company/attorney with a full report on my injury/illness and its examination, diagnoses, treatment, progress notes, etc., in regard to the injury/illness.

ASSIGNMENT OF BENEFITS

In consideration to the Medical Provider treating my injury/illness, I hereby assign to the Medical Provider and authorize and direct my insurance carrier or attorney to pay directly to said Medical Provider, such sums as may be due and owing it for medical service rendered to me or my dependents both by reason of this injury/illness or by reason of any other bills that are due Medical Provider, and to withhold such sums from any settlement, judgment or verdict as may be necessary as to adequately pay said Medical Provider first, I hereby further give lien on my case to said Medical Provider against any and all proceeds of any settlement, judgment or verdict which may be paid to anyone on my behalf as a result of the injury/illness for which I have been treated by Medical Provider. This lien shall not attach to any attorney's fees.

I fully understand that I am directly and fully responsible to said Medical Provider for all medical bills submitted by it for services rendered to me or my dependents, and I agree to pay the same, and that this assignment is made solely for said Medical Provider's additional protection. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover.

This assignment is irrevocable unless: (1) I and the Medical Provider, in writing, terminate this assignment and (2) Medical Provider is fully paid for all of its services relating to my injury/illness.

I hereby state that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

DATE

PATIENT'S SIGNATURE

WITNESS

PARENT/LEGAL GUARDIAN

Acknowledgement of Receipt of Notice of Privacy Practices*

You may refuse to sign this acknowledgement

I, _____ have received a copy of this
office's Notice of Privacy Practices.

Please print name

Signature

Date

For Office Use Only

- We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:
 - Individual refused to sign
 - Communication barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (please specify)
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