PATIENT HISTORY SHEET

Patient Name: _____ **Date of Birth:** _____

Medical History – check YES or NO

	YES	NO		YES	NO		YES	NO
Fever	○	○	Weight Loss	○	○	Hearing Loss	○	○
Ringing in Ears	○	○	Nose Bleeds	○	○	Difficulty Swallowing	○	○
Hoarseness	○	○	Voice Changes	○	○	Sore Throat	○	○
Decreased Vision	○	○	Cataract	○	○	Eye Pain	○	○
Chest Pain	○	○	Palpitations	○	○	Hypertension	○	○
Swollen Neck Glands	○	○	Chronic Cough	○	○	Bad Breath	○	○
Arthritis	○	○	Shortness of Breath	○	○	Abdominal Pain	○	○
Stroke	○	○	Constipation	○	○	Urinary Problems	○	○
Dizziness	○	○	Gout	○	○	Headaches	○	○
Unusual Bleeding	○	○	Convulsions	○	○	Stress	○	○
Asthma	○	○	Skin Rash	○	○	Eczema	○	○
Diabetes	○	○	Depression	○	○	Anxiety	○	○
Gastric Ulcer	○	○	Thyroid Problems	○	○	Veneral Disease	○	○
Heart Disease	○	○	Cancer	○	○	if yes, specify type of cancer _____		

PREVIOUS SURGERIES /COSMETIC PROCEDURES AND YEAR PERFORMED:

_____

_____

_____

_____

MEDICATIONS (including vitamins)

_____

_____

MEDICATIONS ALLERGIC TO: _____

SOCIAL HISTORY (check one)

Use of Alcohol: Never ○ Rarely ○ Moderate ○ Daily ○

Use of Tobacco: Never ○ Previously, but Quit ○ Current Packs/Day ○

Use of Drugs: Never ○ Type/Frequency _____

Excessive exposure at home or work to:

Fumes ○ Dust ○ Solvents ○ Air-Borne particles ○ Noise ○

FAMILY MEDICAL HISTORY

	AGE	DISEASES
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
	_____	_____
Spouse	_____	_____
Children	_____	_____
	_____	_____
	_____	_____

SIGNATURE: _____ DATE: _____

Plastic Surgery Plus

A.K. Bhattacharya. M.D., F.A.C.S

PATIENT INFORMATION

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Today's Date__/__/____

Name _____ M/F Date of Birth __/__/____

Address _____ City _____ State ___ Zip_____

Cell Phone _____ Alternate Phone _____

SS# _____ Marital Status: S M D W Student FT PT

Email Address: _____

PRIMARY INSURANCE

Policyholder _____
Policy# _____
Social Security# of Policy Holder _____
Date of Birth _____ Sex M / F
Relationship to patient _____

SECONDARY INSURANCE

Policyholder _____
Policy# _____
Social Security #of Policy Holder_____
Date of Birth _____ Sex M / F
Relationship to patient _____

Primary Care Physician _____
Address _____ City_____ State___ Zip _____
Phone Number _____ Fax Number _____

Emergency contact information:

Name: _____
Home:_____Cell:_____Work :_____
Relationship to patient: _____

AUTHORIZATION AND CONSENT FOR TREATMENT:

I hereby authorize Dr. A.K. Bhattacharya to examine, evaluate, and treat the above named patient. I further state that I am over 18 years old and authorize to give such consent for treatment (as the patient or guardian/parent/health proxy of the above mentioned patient) OR am an emancipated minor. I acknowledge that the information that I have provide is true and correct, I hereby authorize release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I also acknowledge that I am fully responsible for payment of services of my health insurance coverage. I certify that all health insurance information that I have provided is TRUE and CORRECT.

Signature Relationship Date

A.K. Bhattacharya, MD

FINANCIAL POLICY

Please complete both sides of this form

Thank you for choosing us to provide you with medical care. We are committed to serving you with skill and care. The medical services provided by our office are services you have elected to receive which implies a financial responsibility on your part.

COPAYS: Copayment is due at the time of service. Payments maybe made by cash, check.

SELF-PAY: Payment in full is due at the time of service if you do not have insurance, if our office does not participate with your plan, or our services are not covered under your plan.

MEDICARE: Dr. Bhattacharya is a Medicare participating provider. Medicare as well as your secondary insurance will be billed for you. You are responsible for copayment or deductible amounts stated by Medicare and your secondary insurance company.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance after payment has been received from your primary insurance.

HMO/PPO/MAJOR MEDICAL: Dr. Bhattacharya participates with many plans. You are required to pay your copayment stated on your identification card at the time of service. Any additional amounts due will be billed to you once your insurance has processed your claim.

REFERRALS/AUTHORIZATIONS: You are responsible for obtaining a referral or authorization, if required by your insurance, from your primary care physician. You may be financially responsible for any charges denied due to absence of a referral or authorization. Your scheduled visit may also be rescheduled due to the absence of a referral or authorization.

PATIENT BILLING: A statement of your financial responsibility will be sent to you after your claim has been processed by all of your insurance carriers. Your failure to pay your patient responsibility may result in your account being assigned for collection. Please contact our billing office if you have any questions regarding your bill. A fee of $20.00 will be added to your account for any returned checks.

INTEREST: All interest charge of 1.5% per month will be added to all unpaid patient balances.

COLLECTION: All accounts past due for over 90 days will be sent to collections. A $50.00 service fee or 10% of account balance (whichever is greater) will be added to unpaid balances prior to being sent to collection

I have read the above policies regarding my financial responsibility to Dr. Bhattacharya for providing medical services to me or my dependent. I agree to pay Dr. Bhattacharya any amount due after insurance payment has been made by my insurances and any contractual adjustments have been taken. I understand that if I do not have health insurance I am personally responsible for the full amount of my bill. Further, I understand that if the services provided by Dr. Bhattacharya are not covered under my insurance, for any reason, I am responsible for payment of these charges.

1 understand that it is my responsibility to inform Dr. Bhattacharya's office if there is a change in my health insurance.

PATIENT NAME: _____

RESPONSIBLE PARTY: _____ RELATION TO PATIENT: _____

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____

RELEASE OF MEDICAL INFORMATION REQUEST

Patient medical records are CONFIDENTIAL. Protecting your privacy is very important to us, therefore, according to new federal regulations; we may not discuss or release information to anyone but the patient unless you authorize us to do so. We want to make sure that you receive information that is necessary to assist us in providing quality care and service. Please complete the information below so that we may better serve you and your needs.

Patient name: _____ **Date of Birth:** _____
SS#: _____

I give this office permission to contact me by (initial all that apply):

_____Telephone my home
_____Telephone my work Phone #: _____
_____Leave messages on answering machine
_____Other, explain: _____

if you would like us to discuss your information with anyone other than yourself, please write his/her name below and relationship (i.e. spouse, children, friend, etc.):

_____
_____
_____
_____
_____
_____

Signature of Patient or Personal Representative: _____

Print Name if not patient: _____ **Relationship:** _____

Date: _____

4/14/03

Acknowledgement of Receipt of Privacy Notice

Our practice is dedicated to maintaining the privacy of your confidential, protected health information (PHI). In conducting our business we create records regarding your health status and the health care and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which this practice may use or disclose health information about you. It also describes your rights and our obligations regarding the use and disclosure of that information.

By signing below you acknowledge that you have received our Notice of Privacy Practices.

_____ _____

Patient or Personal Representative Date

_____ _____

Print Name if signature is on behalf of patient Relationship

4/14/03