Personal Medical History Form
Please Print

PATIENT'S LEGAL NAME: _____ TODAY'S DATE: _____

REFERRED BY: _____ BIRTH DATE: _____

REASON FOR VISIT: _____

_____

PLEASE ANSWER ALL OF THE QUESTIONS AS ACCURATELY AS POSSIBLE. IF YOU DO NOT UNDERSTAND THE QUESTION, PLEASE ASK FOR ASSISTANCE.

PERSONAL INFORMATION:

SSN#: _____ E-MAIL ADDRESS: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ WORK #: _____

CELL #: _____ TEXT ___Yes ___ No FAX #: _____

OCCUPATION: _____ MARITAL STATUS (CIRCLE ONE): M S W D

SPOUSE'S NAME: _____

NAME(S) OF CHILDREN AND AGES(S):

1. _____ _____ 3. _____ _____

2. _____ _____ 4. _____ _____

MEDICAL INFORMATION:

PRIMARY CARE DOCTOR: _____ PHONE NUMBER: _____

DRUG ALLERGIES: _____ ALLERGIES TO LATEX: Y or N

LIST PREVIOUS SURGERIES AND DATES:

1. _____ _____ 3. _____ _____

2. _____ _____ 4. _____ _____

LIST MAJOR ILLNESSES AND DATES:

1. _____ _____ 3. _____ _____

2. _____ _____ 4. _____ _____

LIST ANY MEDICATIONS, INCLUDING NON-PRESCRIPTION DRUGS, VITAMINS, AND HERBAL PREPARATIONS:

_____

PERSONAL HISTORY:

HEIGHT: _____ WEIGHT: _____

DO YOU SMOKE? (Circle One): YES NO - IF YES, LIST TYPE AND AMOUNT SMOKED PER DAY: _____

IF YOU HAVE QUIT SMOKING, WHEN? _____

DO YOU DRINK ALCOHOL? (Circle One): YES NO - IF YES, AMOUNT PER DAY: _____

ARE YOU A DIABETIC? YES NO - WHAT TYPE? _____

FAMILY HISTORY:

HAS ANY FAMILY MEMBER HAD ANY OF THE FOLLOWING? (Circle all that apply):

BREAST CANCER	HIGH BLOOD PRESSURE	KIDNEY DISEASE
MELANOMA	HEART DISEASE	DEPRESSION
STROKE	DIABETES	

PAST MEDICAL HISTORY:

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Circle all that apply):

HEART DISEASE	CANCER	STOMACH ULCER
ARTHRITIS	GLAUCOMA	KIDNEY DISEASE
PSYCHIATRIC ILLNESS	ASTHMA	THYROID DISEASE
ANEMIA	AIDS/HIV	BLEEDING DISEASE
TUBERCULOSIS	STROKE	MITAL VALVE PROLAPSE
DIABETES	HEPATITIS	HIGH BLOOD PRESSURE

REVIEW OF SYSTEMS:

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING? (Circle all that apply):

WEIGHT CHANGE	SWOLLEN FEET/ANKLES	SEIZURES
DRY EYES	SKIN RASH	JOINT/MUSCLE PAIN
CHRONIC COUGH	CHRONIC DIARRHEA	SWOLLEN LYMPH NODES
CHEST PAIN	JAUNDICE	EASY BLEEDING
RAPID HEART BEAT	DEPRESSION	EASY BRUISING

THE NEXT QUESTIONS APPLY TO WOMEN ONLY:

AGE YOUR PERIOD BEGAN: _____ NUMBER OF PREGNANCIES: _____

DID YOU BREAST FEED? (Circle one): YES NO

DATE OF LAST MAMMOGRAM: _____ WHERE: _____

DO YOU PERFORM MONTHLY BREAST EXAMS? (Circle one): YES NO

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

X _____ _____

Signature of patient (or parent if patient is a minor) *Date*

ADMINISTRATIVE INFORMATION FORM

PLEASE PRINT

Last name: _____ First Name: _____ Middle Initial: _____

SSN: _____ Date of Birth: _____ E-mail Address: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____ Work Phone #: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Spouse's SSN#: _____

Spouse's Employer: _____ Spouse's Work Phone #: _____

Emergency Contact:

Name: _____ Relationship to Patient: _____ Phone Number: _____

Medical Insurance Information:

Insurance (Primary): _____ SSN# _____

Policy Holder Name (Primary): _____ Policy Holder Date of Birth (Primary): _____

Policy # (Primary): _____ Group# (Primary): _____

Other Insurance:

Insurance (Secondary): _____

Policy Holder Name (Secondary): _____ Policy Holder Date of Birth (Secondary): _____

Policy # (Secondary): _____ Group# (Secondary): _____

Person Responsible Other Than Patient:

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell/Pager #: _____

Medical Cost Agreement:

The patient and Responsible Party listed above hereby agree to any and all amounts and charges submitted by ***Michael S. Beckenstein, M.D., LLC,*** for services rendered during the course of treatment for the Patient. This includes hospitalization, unless ***Michael S. Beckenstein, M.D., LLC*** is other wise obligated to accept payment solely from a third party. The *Patient* and *Responsible Party* hereby acknowledge, understand, and agree that they're financially responsible to ***Michael S. Beckenstein, M.D., LLC*** even though there may be insurance or other third party coverage, and agree that failure to make payment when requested is the basis for legal action, and agree to pay any or all cost of collection, including reasonable attorney fees. The *Patient* and *Responsible Party* herby acknowledge their understanding that the payment is due in full upon receipt of invoice statement. The *Patient* and *Responsible Party* recognize and agree that their obligations to make payment are joint and severable and that ***Michael S. Beckenstein, M.D., LLC, may*** pursue either or both parties for payment, and that they, and not the insurance company are solely responsible for the entire bill, even though the cost of this medical care may exceed the amount reimbursed by third party insurance or payers.

The *Patient* and *Responsible Party* acknowledge, understand, and agree that it is difficult to project the full cost of medical services and treatments in advance, since it is impossible to predict what services, tests, procedures, and/or treatments will be required in the course of medical care. The *Patient* and *Responsible Party* hereby agree to be fully responsible for any and all amounts and charges submitted by ***Michael S. Beckenstein, M.D., LLC.***

There will be a $30.00 charge for all return checks.

X _____ _____ X _____

Patient/Responsible Party Signature Date Witness Signature

X _____ X _____

Please Print Here Please Print Here

AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS / SLIDES / AND / OR VIDEOTAPES

INSTRUCTIONS:

This is a consent document that has been prepared to help inform you concerning permission to take photographs, slides, and/or videotapes and to use these images for a purpose and defined within this consent document.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

INTRODUCTION:

Medical photographs / slides and videotapes may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images.

Additionally, patients may consent to release these medical photography/slides, and videotapes for a stated purpose.

1. CONSENT TO TAKE PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize **Michael S. Beckenstein M.D., LLC** and or his/her associates or licensees to take pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes. I additionally consent to photographs, slides, and/or videotapes of my interview.

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize **Michael S. Beckenstein M.D., LLC** and or his/her associates or licensees to take pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks, for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

Date: _____

Patient Signature: _____

Witness: _____

Consent for Purposes of Treatment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Michael S. Beckenstein, M.D., LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Michael S. Beckenstein, M.D., LLC I understand that diagnosis or treatment of me by Michael S. Beckenstein, M.D., LLC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Michael S. Beckenstein, M.D., LLC is** not required to agree to the restrictions of that I may request. However, if Michael **S. Beckenstein, M.D., LLC** agrees to a restriction that I request, the restriction is binding on **Michael S. Beckenstein, M.D., LLC**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Michael S. Beckenstein, M.D., LLC** has taken action in reliance on this consent.

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.

I understand I have a right to review **Michael S. Beckenstein, M.D., LLC Notice** of Privacy Practices prior to signing this document, The **Michael S. Beckenstein, M.D., LLC** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Michael S. Beckenstein, M.D., LLC** The Notice of Privacy Practices for **Michael S. Beckenstein, M.D., LLC** is also provided on the wall in our office and on **Michael S. Beckenstein, M.D., LLC** Website at MSBMD.com. This Notice of Privacy Practices also describes my rights and the **Michael S. Beckenstein, M.D., LLC** duties with respect to my protected health information.

Michael S. Beckenstein, M.D., LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Michael S. Beckenstein, M.D., LLC, Website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

I hereby authorize Michael S. Beckenstein, MD, LLC to discuss my medical and payment information with:

Name:	Relation
Name:	Relation
Name:	Relation
Name:	Relation