Koch & Carlisle Plastic Surgery and Spa
4855 Mills Civic Pkwy #100
West Des Moines, IA 50265
(515) 277-5555

koch & carlisle PLASTIC SURGERY & SPA

PATIENT INFORMATION

PATIENT FULL NAME: _____ PREFERRED LANGUAGE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

DOB & AGE: _____ RACE: _____ ETHNICITY: ☐ NOT HISPANIC OR LATINO ☐ HISPANIC OR LATINO

SSN: _____ GENDER: _____ EMAIL ADDRESS: _____

EMPLOYER NAME: _____ ADDRESS: _____

OCCUPATION: _____ WORK PHONE: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED

HOW DID YOU HEAR ABOUT OUR CLINIC?

☐ WEBSITE ☐ PATIENT REFERRAL: _____ WHAT PHARMACY DO YOU USE: _____

☐ ADVERTISEMENT ☐ FRIEND: _____ _____

☐ GOOGLE ☐ DR. REFERRAL: _____ LOCATION: _____

OTHER: _____

WHAT IS THE NATURE OF YOUR VISIT?: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: ☐ SPOUSE ☐ PARENT/GUARDIAN ☐ OTHER: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

PRIMARY INSURANCE

NAME: _____ POLICY #: _____ GROUP ID: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

NAME OF INSURED (THE PERSON WHOSE NAME THE PLAN IS UNDER): _____

DATE OF BIRTH OF INSURED (MM/DD/YYYY): _____

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SECONDARY INSURANCE

NAME: _____ POLICY #: _____ GROUP ID: _____

ASSIGNMENT AND RELEASE

I HAVE INSURANCE COVERAGE AND ASSIGN ALL MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS.

_____ _____

SIGNATURE OF INSURED / GUARDIAN DATE

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SECTION I: SURGERY AND ANESTHESIA HISTORY

1. HAVE YOU EVER HAD SURGERY? ☐ NO ☐ YES, PLEASE DESCRIBE:

_____

2. DO YOU HAVE A BLOOD RELATIVE WHO HAD ANESTHESIA COMPLICATIONS OF ANY KIND? ☐ NO ☐ YES, PLEASE DESCRIBE:

_____

SECTION II: SPECIFIC MEDICAL HISTORY

1. ARE YOU PREGNANT? ☐ NO ☐ YES HEIGHT: _____ WEIGHT: _____

HAVE YOU OR DO YOU STILL HAVE:	NO	YES	DESCRIPTION
2. ASTHMA	☐	☐	_____
3. EMPHYSEMA	☐	☐	_____
4. HIGH BLOOD PRESSURE	☐	☐	_____
5. HEART TROUBLE	☐	☐	_____
6. HEPATITIS OR LIVER TROUBLE	☐	☐	_____
7. KIDNEY TROUBLE	☐	☐	_____
8. DIABETES	☐	☐	_____
9. EPILEPSY OR SEIZURES	☐	☐	_____
10. STROKE	☐	☐	_____
11. PROBLEM SCARRING	☐	☐	_____
12. HAVE YOU BEEN ADVISED TO OR HAD PSYCHIATRIC CARE?	☐	☐	_____

13. OTHERS NOT LISTED: _____

SECTION III: SOCIAL HISTORY

1. DO YOU SMOKE? ☐ NO ☐ YES, HOW MUCH? _____

2. DO YOU DRINK? ☐ NO ☐ YES, HOW MUCH? _____

3. DO YOU HAVE CHILDREN? ☐ NO ☐ YES, HOW MANY? _____

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SECTION IV: MEDICATIONS

ARE YOU TAKING ANY MEDICATIONS, VITAMINS OR HERBAL SUPPLEMENTS? ☐ NO ☐ YES, PLEASE LIST:

_____

_____

_____

_____

_____

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS: ☐ NO ☐ YES

COUMADIN, WARFARIN, IBUPROFEN, FULL STRENGTH ASPIRIN, NAPROXEN (CIRCLE ANY YOU HAVE TAKEN IN THE LAST 10 DAYS)

SECTION V: ALLERGIES AND SENSITIVITIES

ARE YOU ALLERGIC TO ANY MEDICATIONS OR LOCAL ANESTHESIA? ☐ NO ☐ YES, PLEASE LIST:

_____

_____

_____

_____

_____

I HAVE READ THIS QUESTIONNAIRE AND DISCLOSED MY MEDICAL HISTORY TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE: _____ DATE: _____

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CONSENT TO COMMUNICATE

PATIENT NAME: _____

PLEASE MARK THE WAYS THAT YOU CONSENT TO US COMMUNICATING WITH YOU:

METHOD	OK TO LEAVE VOICEMAIL	OK TO LEAVE MESSAGE WITH ANOTHER PERSON	PREFERRED CONTACT METHOD(S)	BEST TIME TO CALL*
☐ CALL WORK PHONE	☐ YES ☐ NO	☐ YES ☐ NO	☐	
☐ CALL CELL PHONE	☐ YES ☐ NO	☐ YES ☐ NO	☐	
☐ CALL HOME PHONE	☐ YES ☐ NO	☐ YES ☐ NO	☐	
☐ SEND EMAIL			☐	-
☐ EMAIL APPOINTMENT REMINDERS				
☐ EMAIL MEDICAL INFORMATION				
☐ EMAIL OFFICE SPECIALS				
☐ SEND REGULAR MAIL			☐	-
MAIL TO WHICH ADDRESS: ☐ HOME ☐ OTHER (PLEASE LIST):				
☐ SEND TEXT MESSAGE - IF OK, PLEASE LIST CELL CARRIER (E.G., AT&T):			☐	-
☐ TEXT APPOINTMENT REMINDERS				
☐ TEXT OFFICE SPECIALS				

*BEST TIME TO CALL EXAMPLES: MORNING, AFTERNOON, DAYTIME, EVENING, EMERGENCY ONLY, DO NOT CALL, OR DO NOT LEAVE A MESSAGE

IF IT'S OK TO LEAVE A MESSAGE WITH ANOTHER PERSON, PLEASE LIST THEM:

NAME	DOB	RELATIONSHIP	OK TO RELEASE RESULTS	ANY COMMENTS
			☐ YES ☐ NO	
			☐ YES ☐ NO	

SIGNATURE: _____ DATE: _____

POS Reorder # 1805839

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HIPAA INFORMATION AND CONSENT FORM

PATIENT NAME: _____ DOB: _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

SIGNATURE: _____ DATE: _____

POS Reorder # 1805840