BEND PLASTIC SURGERY

ADAM P. ANGELES, MD, FACS

Physician and Surgeon

Cosmetic, Plastic & Reconstructive Surgery

ELECTRONICALLY FILLABLE **PLEASE PRINT**

PATIENT REGISTRATION FORM

Patient Name:____ Date: __________________
First Middle Last

Address:_____________________________________ City:_________________ State:_____ Zip: ___________

Home Phone:_____________ Cell Phone: _______________ May we leave a message on your phone(Y/N)?_

Email address: ____ May we email you(Y/N)____

Date of Birth:____________ Age: ______ SSN: _________________ Sex:_______ Marital Status?_________

Primary Care Physician:________________________ Referring Physician:_______________________________

Reason for visit:____

INSURANCE INFORMATION

Primary Insurance:____________________________ ID#:___________________ Group#:_________________

Address:_____________________________________ City:_________________ State:_____ Zip: ___________

Policy Holder Name:___________________________ Relationship to insured:_______

Secondary Insurance:__________________________ Ins ID#:________________ Group#:_________________

Address:_____________________________________ City:_________________ State:_____ Zip: ___________

Policy Holder Name:___________________________ Relationship to insured:_______

EMERGENCY CONTACT

Emergency Contact:____

Primary Phone:______________ Other Phone:______________ Relationship:___________________________

Can we disclose medical information to your emergency contact if need be (Y/N)? _______

EMPLOYMENT

Are you employed(Y/N)?_ Employer:__________________________________ Position:_________________

Entered in by:___________________

Date Entered:___________________

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541-749-2282 Fax:541-749-2283

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CURRENT MEDICATION LIST: Please list all current medications and supplements

List current prescription medications	Strength	How often do you take?	How long on this medicine?

ALLERGIES

Medication	Reaction	

PERSONAL MEDICAL HISTORY: Please check any items that you currently have a diagnosis for or have had in the past.

	Abnormal Bleeding/clots		Fibromyalgia		Liver Disease
	Alzheimer’s		Headaches		Lung Disease
	Anemia		Heart Attack		Malignant Hyperthermia
	Anxiety		Heart Disease		Neuropathy
	Arthritis		Heart Murmur		Osteoporosis
	Asthma		High Blood Pressure		Parkinson’s
	Autoimmune Disease		Hemochromatosis		Previous Radiation Therapy
	Back Pain		Hepatitis		Psoriasis
	Benign Breast Disease		High Cholesterol		Schizophrenia
	Blood clot in lung or legs		HIV		Seizures
	Blood Transfusions		Hodgkin’s		Skin Disease
	Cancer of:		Hypertrophic Scarring		Stomach Ulcer
	Cold Sores		Hypoglycemia		Stroke
	Connective tissue disease		Irregular Heart		Substance Abuse
	Depression		Irritable Bowel Syndrome		Tuberculosis
	Diabetes		Kidney Stones/Disease		Thyroid Disorder
	Emphysema		Leukemia		Urinary Incontinence

SURGICAL HISTORY: Please list all surgeries you have had and the approximate dates:

Date	Surgery	Comments

Have you had any complications with anesthesia or PONV (Post-Operative Nausea and Vomiting) (Y/N)?______

FAMILY MEDICAL HISTORY: Please list any medical history in your immediate family’s medical history and their relationship to you.

	Diagnosis	Relationship

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SOCIAL HISTORY: Please answer the following as honestly as possible:

Do you drink alcohol (Y/N)? If yes, how many drinks per week? _________ Just socially(Y/N)?

Have you ever used recreational drugs (i.e. Marijuana, Methamphetamines, Cocaine, or Heroin)(Y/N)? How long?

Have you ever had/have a sexually transmitted disease(Y/N)?_____ If Yes, what?____________________ Treated(Y/N)?_____

Do you smoke tobacco(Y/N)?_____ If yes, how much per day?____________________ Quit(Y/N)?_______ When?_________

Do you exercise regularly(Y/N)?_____ If yes, how often?____

Female – Are you currently pregnant(Y/N)_____ Breast feeding(Y/N)_____ How many children?________ C-Sections?________

REVIEW OF SYSTEMS: Please check all the symptoms that apply now or in the past.

Constitutional
- ☐ loss of appetite
- ☐ fever
- ☐ weight gain
- ☐ weight loss
- ☐ night sweats

Dermatology
- ☐ rash
- ☐ change in color of moles
- ☐ hives
- ☐ History of skin cancer

Ophthalmology
- ☐ diminished vision
- ☐ eye irritation
- ☐ drainage from eyes
- ☐ blurring of vision
- ☐ loss of vision

Allergy
- ☐ runny nose
- ☐ scratchy throat
- ☐ itchy eyes
- ☐ ear fullness
- ☐ sinus congestion
- ☐ stuffy nose

Gastroenterology
- ☐ nausea
- ☐ heartburn
- ☐ jaundice (yellow skin color)
- ☐ vomiting
- ☐ abdominal pain

Gastroenterology, cont.
- ☐ diarrhea
- ☐ constipation

Hematology/ Lympa
- ☐ swollen glands
- ☐ easy bruising

Psychology
- ☐ high stress level
- ☐ depression
- ☐ sleep disturbances
- ☐ eating disorder
- ☐ anxiety disorder

Cardiology
- ☐ chest pain
- ☐ palpitations
- ☐ leg swelling
- ☐ shortness of breath

Ear nose and throat
- ☐ hearing loss
- ☐ snoring

Respiratory
- ☐ shortness of breath
- ☐ chest pain
- ☐ cough wheezing

Endocrinology
- ☐ excessive sweating
- ☐ excessive thirst
- ☐ excessive urination
- ☐ cold intolerance
- ☐ heat intolerance

Musculoskeletal
- ☐ joint swelling
- ☐ joint pain
- ☐ leg cramps
- ☐ joint stiffness muscle pain

Neurology
- ☐ headache
- ☐ tingling numbness
- ☐ seizures
- ☐ dizziness

Urology
- ☐ difficulty urinating
- ☐ blood in urine
- ☐ frequent urination
- ☐ voiding dysfunction
- ☐ recurrent urinary tract infection

Female Reproductive
- ☐ sexually active
- ☐ pelvic pain
- ☐ abnormal vaginal discharge
- ☐ last mammogram_______
- ☐ last pap smear__________

Male Reproductive
- ☐ difficulty with erection
- ☐ difficulty with ejaculation
- ☐ diminished sexual drive

Other
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

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CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize Adam P. Angeles, M.D. to use and disclose the health and medical information of :
____ for the purpose of Treatment, Payment and Health Care Operations.*
(name of patient)

*Treatment (includes activities performed by a physician, nurse, office staff and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultation between other health care providers. This consent includes treatment provided by any physicians who cover my practice by telephone as the on-call physician).

*Payment (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

*Health Care Operations (includes the necessary administrative and business functions of our office).

You may review Bend Plastic Surgery's "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in the CONSENT prior to signing this CONSENT.

Please verify that you have received a copy of our Notice by placing your initials here: _______.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree with your request. If we do agree, we are required to comply with your request* unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that Bend Plastic Surgery Practice has already used or disclosed the information in reliance on this CONSENT.

______________________   ____ or
Date   (Signature of patient)

______________________   ____
Date   (Signature of person authorized by law)

PHOTOGRAPHIC CONSENT FORM

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For Insurance Purposes

In certain cases the insurance company will request photos and chart notes to process a claim. Please complete the below consent.

For Cosmetic Purposes

Photos are required for before and after as well as intra-operatively. These will only be used as part of your care and will be kept as a part of your chart.

Consent

I hereby grant permission for Bend Plastic Surgery to take my picture(s). I hereby grant the use of any of my medical records including illustrations, photographs or other imaging records created in my case.

______________________ ____
Date (Signature of patient)

______________________ ____
Date (Signature of witness)

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Financial Policy

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines.

Payment Options:
We accept Visa, MasterCard, personal checks and cash for insurance co pays. Please be aware that we will add a $35.00 charge to your account for returned checks. **CareCredit and Prosper** healthcare lending plans are available. We reserve the right to send all accounts with balances over 60 days old to an outside collection agency or small claims court if necessary. All accounts sent to collections will be charged a $50.00 processing fee and additional fees associated with the collection of your balance. You will be responsible for all reasonable collections and attorney costs incurred.

Social Security Information
In order to submit claims to insurance companies, along with other necessary billing related issues we require a social security number of the responsible party of this account.

Cancellations and No Show
Cancellations' within 24 hours of your scheduled appointment will result in a $50.00 cancellation fee. Failure to show for your appointment will result in a "no show" fee of $50.00. A $500.00 nonrefundable deposit is required for any surgical procedure.

Insurance
We offer benefit verification as a courtesy, however, it is your responsibility to verify insurance coverage and benefits prior to your appointment or procedure. As a patient, you will be responsible for any co pays, deductibles, additional testing, and services not covered by your insurance. If you do not have your insurance card, or we do not participate with your insurance plan, you can either reschedule your appointment or pay for your visit in full at the time services are rendered. Any balance left after your insurance has paid must be remitted within 30 days a 1.5% monthly finance charge (18% annually) is assessed to all balances over 30 days past due.

Private Party/Uninsured Patients
If you plan to pay privately for your services, please be advised that it is the policy of Bend Plastic & Reconstructive Surgery, PC practice to collect payment in full at the time of service. If you are unable to make payment in full at the time of service, your appointment will be rescheduled to a more convenient time.

Motor Vehicle Accidents (MVA)/Third Party Liability
We will require all claim details (claim#, contact info, billing address) at the time of your appointment; otherwise we will require payment in full for services rendered for each patient being treated for a MVA/other accident-related injury. We will file claim(s) with the motor vehicle or third party insurance company that you designate, provided we receive all necessary information with which to bill. If the claims are denied, or a protracted lawsuit is involved, the patient is responsible to pay the account balance in full. We will bill your private health care insurance if applicable for balance left after your personal injury protection (PIP) exhausted.

Form Fees
Forms and letters requested by our patients will be billed a fee as listed below. This list is not meant to be all inclusive but is merely representative of the items that may incur a charge. This fee covers our administrative expenses related to physician/staff time, photocopying, mailing, etc. Forms such as disability forms, workers comp, letters of medical necessity, family medical leave act forms, and MVA forms all incur a **$25.00 FEE.**

Acknowledgment
I have read and understand the Bend Plastic Surgery financial policy. I understand and agree that regardless of my insurance status, **I am ultimately responsible for the balance on my account for any services rendered, including any attorney fees and costs in arbitration, at trial and on appeal**. I certify that the information provided by me on the patient registration form is true and correct to the best of my knowledge.

__________________________ Patient Name

__________________________ Responsible Party Signature (Print and sign)

_______ - _____ - ______ Social Security Number

__________________________ Date