Valley Plastic Surgery

Steve Lovich, MD

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Full Legal Name ____________**Nickname**
First **Middle** **Last**

Primary Physician **How were you referred to us?**

Social Security # Date of Birth ____/_____/______Drivers Lic #

Home Address City/State/Zip Code

Mailing Address *(if different than home address)*

Home Phone Cell Phone Business Phone

Fax __________________Email Gender: Male Female

Race: Ethnicity: Hispanic/Latino Non-Hispanic/Latino Declined to Answer

Marital Status: Married Divorced Widowed Single Student Status: Full-time Part-time

Occupation Employed: Full-time Part-time

Employer Name/Phone

Employer Address

Responsible Party (if different from patient)
Full Legal Name _________________________________ Relationship
Address City/State/Zip Code
Contact Phone Date of Birth

Emergency Contact
Full Name Contact Phone
Address Relationship

Is your visit related to an injury? Yes No If yes, is the injury work related? Yes No

If yes, name/address of Employer where injured

Claim Number Claim Adjustor
Motor vehicle accident? Yes No Date of injury or accident

Claim Number Claim Adjustor/Phone

Name **Today's Date**

List all medications, vitamins, and herbs that you take regularly and/or sionally.

List all allergies and/or drug sensitivities.

Have you had (circle Y or N) <u>do not leave blank</u>

Jaundice	Y N	Thyroid Disease	Y N
Hepatitis	Y N	Lung disease/shortness of breath	Y N
Risk of AIDS	Y N	Asthma	Y N
High blood pressure	Y N	Bleeding Tendency	Y N
Diabetes	Y N	Blood Disease	Y N
Requiring Insulin	Y N	Kidney Disease	Y N
Epilepsy, seizures	Y N	Stomach problems	Y N
Depression	Y N	Ulcers	Y N
Stroke	Y N	Gall bladder problems	Y N
Bone disease	Y N	Bowel disease	Y N
Arthritis	Y N	Bad reaction to anesthesia	Y N
Heart disease	Y N	Ever taken steroids	Y N
Chest Pain	Y N	Cancer	Y N
Pacemaker	Y N	Implanted defibrillator	Y N

Previous serious illness:

Other current or chronic illness

Occupation Could you be pregnant? **Y N**

Height Weight lbs. Alcohol Use? **Y N** Non-prescription drug use? **Y N**

Do you smoke? **Y N** How much? Quit? **Y N** When?

Family History
What diseases run in your family?

Does anyone in your family have the same problem as you?

Do you live alone? Yes No

List all previous surgeries

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communications of PHI may be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Phone: **Cell Phone:**

Ok to leave detailed m ge

Leave m ge with call back number only

Written Communication:

Ok *to mail to my home*

Ok to mail to my work/office

Work Phone:

Ok to leave detailed m ge

Leave m ge with call back number only

Fax to this Number

Email:

Ok to email me all medical information

OK to leave Personal Health Information with the following Person(s):

Name Phone #

Name Phone #

Name Phone #

I have an Advance Directive on file NO YES If Yes Where?

I would like a copy of an Advance Directive to complete. YES NO

You may request and review Steve L Ds Notice of Privacy Practices for ormation about the uses and disclosures. ***Please verify that you have been offered a copy of our Notice of Privacy Practices by initialing.*** ________________

Patient Initials Here

I understand that I have the right to revoke this consent, provided that I do so ***in writing***, except to the extent that Steve Lovich, MD, has already used or disclosed the information in reliance on this consent.

NOTE: Uses and disclosures may be permitted without prior consent in the case of an emergency.

I authorize Steve Lovich, MD to use and disclose my personal health information to other doctors involved in my continuing care:

Print Patient Name **DOB**

Patient or Guardian Signature **Today's Date**

PLEASE READ AND SIGN THE FOLLOWING CONSENT FORM

I understand that in consideration of the services rendered, I am obligated to pay Dr. Steve Lovich in accordance with his regular rates, terms or contractual agreements. I understand that I am responsible for any and all services not covered by insurance. I understand that Dr. Lovich or his agents shall, as a courtesy to me, bill my insurance company. I authorize the release of any information to my insurance company necessary for the processing of my claim. I further authorize my insurance company to pay Dr. Lovich directly any benefits due.

PROCEDURES NOT COVERED BY INSURANCE

I understand that in consideration of the services rendered, I am obligated to pay Dr. Steve Lovich in accordance with his ***"Policy on Patient Accounts".***

You may request and review Steve Lovich, MD's "Policy on Patient Accounts" for additional information. Please verify that you have been offered a copy of our "Policy on Patient Accounts" by initialing.

Patient Initials Here

Print Patient Name **DOB**

Patient or Guardian Signature **Today's Date**

Insurance information and Assignment of Benefits

Please have your insurance card for the Receptionist.
If you do not have your card with you, be prepared to pay for your office visit today.

YOU DO NOT NEED TO FILL THE INSURANCE PORTION OUT IF YOU ALREADY PROVIDED YOUR INSURANCE CARD AT CHECK IN.

Primary Insurance

Insurance Company/Plan Name Co-Pay

Name of [illegible] Date of Birth

Phone ________________________

ID# Group# Relationship

Secondary Insurance

Insurance Company/Plan Name Co-Pay Amt

Name of [illegible] ate of Birth

Address ____Phone

ID# Group# ______________________Relationship