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** ________________

PLEASE WRITE all medications, vitamins, and herbs that you take regularly and/or occasionally.
WE WILL NOT ACCEPT A SEPARATE LIST OF MEDICATIONS YOU MUST WRITE THEM IN.

List all allergies and/or drug sensitivities.

Have you had (circle Y or N) do not leave blank

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 message*

☐ *Leave message with call back number only*

Work Phone: ☐

☐ *Ok to leave detailed message*

☐ *Leave message with call back number only*

☐ *Fax to this Number*______________________

Written Communication: ☐

☐ Ok *to mail to my home*

☐ *Ok to mail to my work/office*

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 Lovich, MD's "Notice of Privacy Practices" for additional information about the uses and disclosures. ***Please verify that you reviewed our laminated sheet of the Notice of Privacy Practices by initialing here.*** ___________________

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 a copy or review Steve Lovich, MD's "Policy on Patient Accounts" for additional information. Please verify that you have reviewed our laminated sheet titled "Policy on Patient Accounts" by initialing here. ________________
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 ***Policy Holder*** ______________________________ Date of Birth ________________

Insured's Address ______________________________ Phone ________________

ID# ____________________ Group# ________________ Relationship ________________

Secondary Insurance

Insurance Company/Plan Name ______________________________ Co-Pay Amt ____________

Name of ***Policy Holder*** ______________________________ Date of Birth ________________

Address ______________________________ Phone ________________

ID# ____________________ Group# ________________ Relationship ________________