TEXOMA
PLASTIC SURGERY
Phillip J. Stephan, M.D., F.A.C.S.

Patient Information:

Today's Date: _____
Referred by: _____
Pharmacy: _____ Address:_____
Primary Care Doctor:_____

Patient's Legal Name: _____
Preferred Name: _____ Guardian (if minor) _____
Address_____
City_____ State_____ Zip_____
Email_____ Home Phone_____
Work Phone_____ Cell Phone_____
Date of Birth: _____ Sex: _____
SS#:_____ Preferred Language: _____
Driver's License #:_____ Expiration: _____

Marital Status (circle one)

Single Married Separated Divorced Widowed

Employment (if minor, responsible parties)

Employer_____
Position_____ May we call you at work? _____

In Case of Emergency

1.) Name_____
Relationship_____ Phone_____
2.) Name _____
Relationship_____ Phone_____

……

I understand that I am financially responsible for all charges. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. We accept cash, checks, money orders, and credit cards (Visa, MasterCard, AMEX and Discover.)

_____ _____

Signature **Date**

2200 Kell Blvd Wichita Falls TX, 76309 940-264-2600 FAX 940-264-2601
drphilstephan.com

Health History and Anesthesia History

Patient Name: _____ Date: _____
Age: _____ Weight: _____ Height: _____
Reason for Visit Today: _____
Primary Care Doctor: _____ Other Doctors: _____
Allergies and Reactions to Medications: _____
_____

Do you take ANY diet pills, Natural Herbs, or Health Food Supplements? ___**YES**___**NO**
PLEASE LIST ALL MEDICATIONS BELOW:

NAME	REASON FOR TAKING	FREQ/DOSAGE

Have you taken any steroids in the last year? If **YES,** please explain:_____
_____
Previous Surgeries: _____
_____

Family history of breast cancer? ___**YES** ___**NO** If so, who: _____ Age diagnosed: _____
Have you ever had a Mammogram? ___**YES** ___**NO** If so, where: _____ Date**:** _____
Are you pregnant? ____**YES** ____**NO** Date of your last menstrual period: _____
Are you finished having children? ____**YES** ____**NO**
Do you take Asprin on a regular basis? ___**YES** ___**NO**

DO YOU USE ANY TYPE OF NICOTINE PRODUCTS? ____YES ____NO
If so, please list:_____

Circle all that apply-Past/Current History

Lung Disease Mitral Valve Prolapse Asthma Neck Problems Fever Blisters

Liver Disease Heart Disease Hepatitis Sleep Apnea Abnormal/Excessive Bleeding

Kidney Disease Chest Pain HIV Dry Eyes Taken Accutane within last year

High BP Diabetes Seizures Keloids Blood Disorders

CHF Stroke Chronic Acid Reflux Difficulty Opening Mouth

Other: _____

Have you had any reactions, allergic or otherwise, to the medications you received in the past during surgical procedures? _____

Is there a family history of unexpected death following general anesthesia or exercise; family or personal history of malignant hyperthermia (MH), a muscle or neuromuscular disorder, high temperature following exercise; personal history of muscle spasm, dark or chocolate colored urine, or unanticipated fever immediately following anesthesia or serious exercise? **YES** **NO**

Are any of your teeth: **LOOSE** **FRAGILE** **CAPPED** **FALSE**

Do you drink alcoholic beverages? **YES** **NO**

Have you had any lab work or ECG within the last 6 months? **YES** **NO** If so, where:_____

Have you had a fever, infection, productive cough, or taken antibiotics within the last two weeks? **YES** **NO**

Have you ever been told that you have a difficult airway? **YES** **NO**

Any concerns regarding undergoing anesthesia? _____

Patient Signature_____

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PLASTIC SURGERY PA

Do you have Insurance? **YES** or **NO**

If yes, proceed to the following. If no, please sign and date at the bottom.

(Please note: This information is for the POLICY HOLDER)

Primary Insurance: _____

Policy #: _____ Group #: _____

Name of Policy Holder: _____

Policy Holder's SSN: _____

Policy Holder Date of Birth: _____ Relation to Patient:_____

Secondary Insurance: _____

Policy #: _____ Group #: _____

Name of Policy Holder: _____

Policy Holder's SSN: _____

Policy Holder Date of Birth: _____ Relation to Patient: _____

……...

Assignment of Benefits: I hereby sign all medical and/or surgical benefits for private insurance to: Texoma Plastic Surgery. The assignments will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure the payment.

Sign: _____ **Date:**_____

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WICHITA FALLS, TEXAS 76309

I understand that my estimate of insurance benefits is not a guarantee of payment by my insurance company. I understand that the estimate reflects benefits available, deductibles, coinsurance that apply and is subject to my eligibility on the date of service.

I further understand that any unpaid balance due to Texoma Plastic Surgery remaining is my financial responsibility.

Patient/Responsible party signature:

X_____

Date: _____

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2200 KELL BLVD.
WICHITA FALLS, TEXAS 76309

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Protecting Your Privacy: Protecting your privacy and your medical information is at the care of our business. We recognize our obligation to keep your information and secure and confidential weather on paper or the Internet. At Texoma Plastic Surgery, privacy is one of our highest priorities.

Keeping your Information: Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees will access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to establish security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information: In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this to provide service to you, to process your claims and to bring you health that might be of interest to you.

Keeping Information Accurate: Keeping your health information accurate and up-to-date is very important, like name, address and insurance information.

How/Way information is shared: we limit who receives information and what type of information is shared.

_____ _____

Signature **Date**

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Patient consent and acknowledgment of receipt of privacy notice

I understand that as part of the provision of healthcare services, Texoma Plastic Surgery creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for a future care or treatment.

I have been provided with a notice of privacy practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices in prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made I rely on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or an electric format, or confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.

2. A photo copy or fax of this consent is as valid as the original.

3. I have the right to request that the use of my protected health information, which is used or disclose for the purposes of treatment, payment or healthcare operations, be restricted. I also understand that the practice and I must agree to any restrictions on the use and disclosure of my protected health information that I request in writing and agreed to terminate any restrictions on the use and disclosure of my protected health information which have been previously agreed-upon.

Patient's Name (Printed)	**Date**
Patient's Signature (Or Guardian If Minor)	**Social Security**

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Photographic Authorization and Release

By signing my signature below, I authorize Dr. Philip J. Stephan, and his employees or agents to photograph me and/or make an electronic recording of me (hereafter referred to as photographic or electronic reproductions) in connection with the plastic surgery procedure(s) he has performed or may perform. This consent includes the taking of photographic electronic reproductions of any part of my body.

I authorize the use of any such photographic or electronic reproductions of me for purposes of my treatment, educational endeavors, and quality assurance review. I hereby grant permission for the use of any of my medical records including illustrations, photographs, or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by the American Board of Plastic Surgery, Inc. to the extent that I am not identifiable from such photographic or to physicians, health professionals, And members of the public for scientific or educational purposes or publication in newspapers, magazines, and other public media as may be deemed appropriate by Dr. Phillip J. Stephan.

I understand that I may refuse to consent to the taking of any photographic or electronic productions that are not intrinsic to the operation or procedure without prejudice to my care.

Neither I, nor any member of my family, will be identified by name in any form of publication. Where ever possible, the photos will be cropped so as to show only the pertinent information, but not personally identifying information. I understand that in some circumstances, the photographs may portray features that will make my identity recognizable.

I have entered into this agreement, in order to assist scientific treatment, education, public relations, and/or charitable goals and hereby waive any right for compensation for these uses. I, and my successors, hereby hold Dr. Phillip J. Stephan, his employees, and any other person participating in my care, harmless from any claim or compensations resulting from the activities authorized by this consent.

_____	_____	_____
Patient's Name (Printed)	**Witness Signature (Printed)**	**Date**
_____	_____	_____
Signature	**Witness Signature**	**Date**

By My signature below, I authorize permission for use of photographs on the internet and/or website

_____	_____	_____
Signature	**Witness Signature**	**Date**

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CONFIDENTIALITY CONSENT FORM

Please list the family member and/or persons, if any, whom we may inform about your medical conditions and your diagnosis. If anyone calls regarding your medical conditions and are not listed on this form, WE CANNOT GIVE THEM ANY INFORMATION... it is the law!

1._____ # _____
2._____ # _____
3._____ # _____
4._____ # _____
5._____ # _____
6._____ # _____

_____ _____
Patient's Name (Printed) **Date**

_____ _____
Patient's Signature (Or Guardian If Minor) **Date**