Welcome to the DRMC Plastic Surgery Office

A Service of DuBois Regional Medical Group

Name: _____Today's Date: _____
First Middle Last

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: ( )_____ Birth Date: _____ Age: _____ Sex: M F

E-mail Address: _____ May send information here? Yes No

Occupation: _____ SSN: _____

Employer: _____ Years There: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Work Phone: ( ) _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: ( )_____ Birth Date: _____ Age: _____

Occupation: _____ SSN: _____

Employer: _____Years There: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Work Phone: ( )_____

Name of Spouse: _____ Birth Date: _____ Age: _____

Occupation: _____ SSN: _____

Employer: _____ Years There: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Employer's Telephone: ( )_____

DRMC Plastic Surgery

In Case of Emergency, Contact: _____ Relationship: _____

Home Phone: ( )_____ Work Phone: ( )_____

Referred By: _____

Reason for Referral: _____

Name of Primary Care Physician (PCP):_____

Phone Number of PCP: ( )_____

Address: _____

Insurance Information

Patient's Name: _____ Date of Birth: _____
First Middle Last

[Primary Insurance]

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____

Group Number: _____ Policy ID Number: _____

[Secondary Insurance]

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____

Group Number: _____ Policy ID Number: _____

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MEDICAL HISTORY

Please Check All that Apply to You:

- ❒ Arthritis _____
- ❒ Asthma _____
- ❒ Blood/Bleeding Disorder _____
- ❒ Depression/Anxiety _____
- ❒ Diabetes _____
- ❒ Gastrointestinal Problems _____
- ❒ Gynecological Problems _____
- ❒ Heart Disease _____
- ❒ Hepatitis _____
- ❒ High Blood Pressure _____
- ❒ HIV/AIDS _____
- ❒ Kidney/Bladder Problems _____
- ❒ Liver Disease _____
- ❒ Lung Problems _____
- ❒ Prostate Problems _____
- ❒ Stomach Problems _____
- ❒ Seizures/Epilepsy _____
- ❒ Skin Disorder _____
- ❒ Shingles _____
- ❒ Stroke _____
- ❒ Thyroid Problems _____
- ❒ Tuberculosis _____
- ❒ Ulcers _____

Surgical History

Type of Surgery	Date	Type of Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies

Reactions

- ❒ Penicillin _____
- ❒ Sulfa _____
- ❒ Morphine _____
- ❒ Latex _____

Reactions

- ❒ CT Dye_____
- ❒ Aspirin _____
- ❒ Tape _____

Other Allergies	Reactions
_____	_____
_____	_____
_____	_____
_____	_____

DRMC Plastic Surgery

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY – CONTINUED

Current Medications
Please list any medications you are currently taking, including prescription medications, over-the-counter medications (for example, aspirin, and vitamins), herbal medicine or alternate therapy.

Name of Medication	Dose	How often do you take it?	When did you start taking it?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

When was your last tetanus shot? _____

Do you use (or did you use):

- ❒ Tobacco Packs per Day _____
- ❒ Alcohol How Often _____
- ❒ Illegal Drugs Type/Amount_____

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Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY – CONTINUED

Family History

Have any of your relatives had a chronic illness (for example, cancer, heart disease, diabetes)?

Relative	Specify Chronic Illness(es)	Living	Deceased
Biological Mother	_____	❒	❒
Biological Father	_____	❒	❒
Maternal Grandmother	_____	❒	❒
Maternal Grandfather	_____	❒	❒
Paternal Grandmother	_____	❒	❒
Paternal Grandfather	_____	❒	❒
Siblings	_____	❒	❒
Aunt(s)	_____	❒	❒
Uncle(s)	_____	❒	❒

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts. See our complete financial policy for details.

Method of Payment for Today's Visit: ❒ Cash ❒ Check ❒ Visa/MC

Signature of Patient or
Responsible Party: _____ Date: _____

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HEALTH INFORMATION CONTACT AGREEMENT

Patient Name: _____ Date of Birth: _____

Please contact me with my health information (test results, etc.) as follows:

By Telephone:

❒ Home Number_____

❒ Work Number_____

❒ Cell Number _____

May leave messages on my home answering machine: ❒ Yes ❒ No

May leave messages on my work voice mail: ❒ Yes ❒ No

May leave messages with: _____

May release medical information to the following:

_____

_____

Patient Signature: _____ Date: _____

DRMC Plastic Surgery

PHOTOGRAPH CONSENT

In connection with and in consideration of the plastic and reconstructive surgery and other medical services which I have been receiving or am about to receive from my physician Algie M. LaBrasca, D.O. and DRMC Plastic Surgery, I consent that clinical photographs may be taken of me or parts of my body, under the following conditions:

The photographs shall be taken only with the consent of my physician and under such conditions and at such times as may be approved by my physician.

My physician or assigned office staff shall take the photographs.

The photographs shall be used for medical record purposes and shall remain the property of my physician and DRMC plastic surgery.

I may obtain a copy of these photographs for a small fee to cover the office cost.

I consent to the photographing of the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures.

Patient Signature: _____ Date: _____

DRMC Plastic Surgery

Patient Consent for Health Information to be Communicated by E-Mail

Name: _____

Address: _____

E-mail Address: _____

Telephone Number: _____

Conditions for the Use of Your E-mail
By consenting to the use of e-mail with Dr. Algie M. LaBrasca for Plastic Surgery, you agree that:

a.) DRMC Plastic Surgery may forward e-mails as appropriate for diagnosis, treatment, reimbursement, and other related reasons. As such, DRMC Plastic Surgery staff members may have access to e-mails that you send. Such access will only be to such persons who have a right to access your e-mail to provide services to you. Otherwise, DRMC Plastic Surgery will not forward e-mails to independent third parties without your prior written consent, except as authorized or required by law.

b.) DRMC Plastic Surgery reserves the right to save your e-mail or information contained within your e-mail in your medical record.

Patient Acknowledgement and Agreement
DRMC Plastic Surgery will use reasonable means to protect the privacy of your health information sent by e-mail. However, because of the risks associated with the use of the internet and e-mail, Dr. Algie M. LaBrasca cannot guarantee that e-mail communications will be confidential. Additionally, Dr. Algie M. LaBrasca will not be liable in the event that you or anyone else inappropriately uses your e-mail. Dr. Algie M. LaBrasca will not be liable for improper disclosure of your health information that is not caused by Dr. Algie M. LaBrasca intentional misconduct.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communications of e-mail between DRMC Plastic Surgery and me, and consent to the conditions outlined herein, as well as any other instructions that DRMC Plastic Surgery may impose to communicate with me by e-mail. Any questions I may have had were answered.

Patient Signature: _____ Date: _____

DRMC Plastic Surgery

Authorization for Release and Assignment:

I authorize DRMC Plastic Surgery and DuBois Regional Medical Group to release information to insurance carriers concerning my illness and treatments for the purpose of payment. I assign all payments for medical services rendered to myself and my dependents. I understand I am responsible for any amount not covered by my insurance including co-pays, deductibles and non-covered services.

Signed: _____Date:_____

Consent to Treatment and Acknowledgment of Sample Medications:

I consent to examination and/or medical care as prescribed by the physician. I understand that sample medications are for patient use and shall be dispensed in non-childproof containers. I understand I will be instructed on the use and indication of any sample medication(s) and possible side effects or adverse reactions. This authorization is in force unless revoked in writing.

Signed: _____Date:_____

DRMC Plastic Surgery

Acknowledgement of Receipt of "Notice of Privacy Practices"

In this Notice "you(r)" means you, and/or your, minor dependent that is being treated. As required via the federal HIPPA regulations (Health Insurance Portability and Accountability Act) the providers at our medical practice, along with its nursing and administrative staff, under the guidance of the Physician(s), may share you(r) health information for the purposes of treatment, payment, and health care operations.

I understand that my health information may be used for the purposes of treatment, payment, and health care operations such as (but not limited to):

A. Sharing my health information among providers (within and outside our medical practice) on a need to know basis, in order to medically treat me.
B. Using my health information for medical billing purposes, including providing referrals to medical specialists, when necessary and appropriate.
C. Sharing my health information with health insurance firms, government agencies, or other claims payers that request information related to benefits determinations, medical claims filed for visits, treatments, admissions, and other billing matters.
D. Using my health care information for health care operations, including monitoring the quality of care, audits, surveys, and carrying out other medical practice business and administrative activities.
E. My permission is given today for any medical treatment including, but not limited to, examination, injections, diagnostic testing, or medical procedures as may be deemed advisable by members of this Medical Center.

I understand that all reasonable efforts will be made to protect the privacy of my health information whether maintained as a paper file or electronic file, and regardless of how it is communicated (verbally, or via fax, paper, or electronically).

I have been given the opportunity to read the "Notice of Privacy Practices" which outlines in more detail how my health care information is used and shared with others. The "Notice of Privacy Practices" explains when I need to give further approval for the providers to use my health information or share it outside of the medical practice, and when my permission is not needed for the providers to use my health information or share it outside of the medical practice (such as: required by law, public health activities, and so forth).

I understand that this medical practice has reserved the right to change the "Notice of Privacy Practices" at any time. I may obtain a current copy of the "Notice of Privacy Practices" by contacting the Privacy Officer of this medical practice.

My signature below constitutes my acknowledgement that I have been provided the opportunity to read and obtain a copy of the "Notice of Privacy Practices."

Patient Signature: _____

_____ _____

Print Full Name Date