PREMIER PLASTIC SURGERY, PC
ACQUA BLU MEDICAL SPA & PLASTIC SURGERY CENTER

Brian Heil, MD FACS, Board Certified Plastic Surgeon
Ana Cristina Busquets, MD, FAAD, Board Certified Dermatologist

PATIENT REGISTRATION

Thank you for choosing our practice. In order to serve you properly, we need the following information. All information will be confidential. Please print.

Reason for today's visit: ____

Was this due to an accident? YES / NO. Date of accident_______________ If yes, was this a motor vehicle or worker's compensation accident (please circle one).

Patients Name:___________________________DOB:__________Age:______

Address:_____________________City:____________State:___Zip:_________

Home Phone:____________ Cell Phone:____________ Work Phone:______________

Marital Status: S M W D Sep Sex:____________ Social Security #: -______________

E-mail address:____

Employer:________________________ Occupation: ____________________

Address:_____________________ City:____________State:___ Zip:_________

Do you have medical insurance: YES / NO If no, how do you intend to pay today? Cash Check Credit Card
Insurance name & address:____

Subscriber Name:______________________Subscriber's Employer:____________

Policy#:________________________ Subscriber's DOB:_____________

Group #:____________________ Is this through your employer? YES NO

Subscriber's Social Security #______________ Is there additional insurance? YES NO

2nd Insurance Name & address:____________________________________

Subscriber Name:________________________Policy#:____________________

Group#_________________________ Relationship to patient:______________

Primary Care Physician:________________________ Phone#_______________

Emergency contact name, relationship & phone#:___________________________

How did you hear about our Practice:_____________________________________

______________________________ ________________________
(Patient, parent/guardian signature) (Today's Date) 03/09

PREMIER PLASTIC SURGERY

DERMATOLOGY HEALTH HISTORY FORM

PATIENT NAME:____DOB:________________

Please answer all questions as accurately as possible. If you do not understand the question, please ask for assistance.

Height:_____________________ Weight:____________________

I.<u>DERMATOLOGY HEALTH HISTORY</u> Have you had or do you currently have any of the following conditions? Please place a check mark next to them

Diagnosis	**Currently have**	**Have had**	**Duration/how long ago?**
Acne			
Actinic keratosis			
Atypical moles (dysplastic nevi)			
Basal cell carcinoma			
Cysts			
Chickenpox			
Dermatitis/eczema			
Hair disorder			
Herpes simplex			
Hives			
Hyperhidrosis (excessive sweating)			
Lupus			
Melanoma			
Nail disorder			
Rosacea			
Sarcoid			
Scars/keloids			
Shingles			
Skin ulcer			
Squamous cell carcinoma			
Other skin cancer			
T cell Lymphoma (mycosis fungoides)			
Vitiligo			
Warts			
Other (specify)			

Additional information (physician will fill out):

____

____

____

II. PAST MEDICAL HISTORY: Have you ever had any of the following conditions? Please place a check mark next to them

Arthritis		Heart disease	
Asthma		Heart valve disorder	
Anemia		Hepatitis/Liver disease	
AIDS or HIV+		High Blood pressure	
Bleeding disorder		Osteoporosis or osteopenia	
Cancer (non-skin)		Pacemaker	
Cataracts		Rheumatic Fever	
Complications with anesthesia		Seizure/epilepsy	
Crohns Disease/Colitis		Stomach ulcer	
Depression/Mental illness		Stroke/TIA	
Diabetes		Thyroid disease	
Glaucoma		Tuberculosis	
Gynecologic problems		Renal disease or kidney stones	

Additional information (physician will fill out):

____
____
____
____
____

III. PAST SURGERIES and DATES:

____

____
____

IV. FAMILY HISTORY Please check any of the following conditions which a blood relative may have had

Acne		Psoriasis		Heart disease	
Atypical moles		Vitiligo		High blood pressure	
Eczema		Sarcoid		Kidney disease	
Lupus		Depression or mental illness		Stroke	
Melanoma		Diabetes		Thyroid disease	
Other *skin* cancer		Other cancer (breast, colon, pancreas,etc)		Vitiligo	

Other:

____
____

V.REVIEW OF SYSTEMS: Do you have now or have had within the past year? Please place a check mark next to them.

Fatigue		Nausea/vomiting or diarrhea	
Fevers/chills/night sweats		Joint or muscle pain	
Weight loss		Depression or mood change	
Weight gain		Swellings hands/feet	
Headaches		Swollen glands	
Dizziness		Easy bleeding	
Difficulty sleeping		Easy bruising	
Blurry vision		Dry skin	
Dry or itchy eyes		Itchy skin	
Ringing in the ears		Oily skin	
Nose bleeds		Sensitive skin	
Chronic or recurrent cough		New or changing lesions/moles (size/color)	
Wheezing		Irritated or bleeding lesions	
Chest pain		Hair loss	
Rapid or irregular heart beat		Nail changes	
Abdominal pain			

Additional information (physician will fill out):

____

____

VI. List all current MEDICATIONS/SUPPLEMENTS:

1.____ 6.___________________________________

2.____ 7.___________________________________

3.____ 8.___________________________________

4.____ 9.___________________________________

5.____ 10.__________________________________

Any others:____

Retin-A?	Yes	No
Strength:		
Time in use:		
Accutane?	**Yes**	**No**
Last in use:		
Tetracyclines?	**Yes**	**No**

VII. ALLERGIES:

No known drug allergies

OR

To oral medications? ____

To foods or topical products (please place a check mark next to each of them):

Adhesives		Eggs		Citrus fruit		Ragweed	
Aloe vera		Milk		Pineapple		Hydroquinone	
Alcohol based products		Nuts		Shellfish/seaweed		Retin A retinoids	
Dyes		Papaya/kiwi		Garlic,onions,chives		LATEX	
Perfumes		Strawberries		Plants or flowers			

Any others: ____

VIII.SOCIAL HISTORY:

Occupation:			
Smoker?	Current # cigarettes:	Previous Quit date:	Never
Alcohol?	Current # drinks:	Previous Quit date:	Never
Skin cancer risk	Burn	Burn-Tan	Tan
Do you use tanning booths?	Yes How often?	No	
Sunscreen use?	Yes	No	
Have you ever had chemical peels or microdermabrasion?	Yes	No	
Do you wax or laser for hair removal?	Yes	No	
Have you recently had facial surgery or facial resurfacing?	Yes	No	
Botox or Fillers?	Yes	No	
What is your ethnic background?			
Do you exercise regularly?	Yes How often:	No	
Were you sent by another doctor for consultation?	Yes Who:	No	

IX. *Female clients only*: Check Yes or No

	YES	NO
Breastfeeding?		
Oral Contraceptives?		
Hysterectomy?		
Peri-menopausal?		
Pregnant or trying?		

I verify that the above information is true and accurate to the best of my knowledge.

X____ **Date**_________________

(Signature of patient or parent/guardian if minor)

3/09

PREMIER PLASTIC SURGERY
AUTHORIZATION / ASSIGNMENT / RELEASE / CONSENT

PATIENT NAME: ____

MEDICARE: Statement to permit payment of Medicare benefit to physician, provider, and patient.

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carries any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

If you have:
MEDICAID: Statement to permit payment of medical benefits to physician and provider.

I certify that the information given to me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Department of Public Welfare or its intermediaries or carries any information needed for this or related Medicaid claim. I request that payment of services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to D.P.W. for payment.

ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical benefits per appropriate assignment(s) to Premier Plastic Surgery, PC. I understand that I am ultimately responsible to the physician for charges not covered by my insurance. All co-insurance and deductibles are my responsibility per my contract with my insurance company.

______________________________ ______________________________
Patient or Authorized Person Date

RELEASE OF INFORMATION

I authorize the release of medical records, any related studies, and other information to my family physician, the doctor to whom I am referred, my legal counsel and to the applicable third-party payer.

______________________________ ______________________________
Patient or Authorized Person Date

PHOTOGRAPH CONSENT

I agree that Dr. Brian V. Heil MD, Ana C. Busquets, MD or designated representatives or the practice may take and use pre-treatment, pre-operative, post-treatment and post-operative photographs of my person for <u>confidential clinical record purposes</u>, and that such photographs shall remain the property of Premier Plastic Surgery, PC and Acqua Blu Medical Spa.

______________________________ ______________________________
Patient or Authorized Person Date

____
Witness 3/09

Premier Plastic Surgery, PC

Brian Vassar Heil, MD FACS	***Board Certified, Plastic Surgeon***
Ana Cristina Busquets, MD FAAD	***Board Certified, Dermatologist***

FINANCIAL POLICY

Premier Plastic Surgery believes that part of a good health care practice is to establish and communicate a financial policy to our patients. An informed and responsible patient should never have a credit problem with our practice.

Payment is expected on the same day of each visit prior to the physician encounter. We accept cash, checks, Visa, MasterCard, and American Express. Medi-Spa treatments sold as packages are non-refundable.

PAYMENT will include any unmet deductible, co-insurance, co-payment amount, cosmetic or non-covered charges from the insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit.

We are participating providers for most insurance carriers. We will file all primary and secondary insurance claims for you. We do not file with third parties but will provide you with the information for you to do so. **Please remember that insurance is a contract between the patient and the insurance company and ultimately you are responsible for the payment in full to Premier Plastic Surgery, PC.**

Occasionally an *established* patient incurs unusually high financial responsibility for charges provided by one of the physicians. We will work with these patients to establish an appropriate payment plan and obtain a signed financial agreement.

In the interest of prudent medical care, all excisions are sent to an outside laboratory for pathology. The patient will receive a bill in accordance with their insurance plan.

RETURN CHECK will incur a $35.00 service charge. You will be asked to bring cash or money order to cover the amount of the check plus the service charge.

ACCOUNTING PRINCIPLES – Payments and credits are applied to the oldest charge first, except for insurance payments, which are applied to the corresponding charge.

DISABILITY FORMS, INSURANCE FORMS, COPIES OF MEDICAL RECORDS, ETC, require office staff time and time away from patient care for the physicians. Therefore, we require 2 business weeks to complete the forms and requests and a fee may be charged.

AUTHORIZATION / FINANCIAL INFORMATION

1. I hereby authorize the release of medical information to my insurance company concerning my medical condition and treatment for the purpose of claim payment.
2. I assign Premier Plastic Surgery ALL payments from my insurance company for medical services rendered to myself and dependents.
3. I agree that if my insurance company sends payment to me for the medical services instead of Premier Plastic Surgery, I will immediately pay the amount due to Premier Plastic Surgery.
4. I agree it is my responsibility to understand my insurance benefits and to notify Premier Plastic Surgery immediately of any changes to my insurance coverage.
5. I fully understand that I am financially responsible for any co-payments, deductibles, co-insurance, cosmetic or non-covered services as determined by my insurance carrier.

Patient Signature: ____ Date: ______________
Witness: ____ Date: ______________ revised 06/10

Premier Plastic Surgery
Acqua Blu Medical Spa & Plastic Surgery Center
Brian Vassar Heil, MD FACS
Ana Cristina Busquets, MD FAAD
144 Emeryville Drive, Cranberry Twp., PA 16066
1614 Washington Rd., Upper St. Clair, PA 15241

RELEASE OF INFORMATION

To insure proper and timely handling of your medical information which have been ordered by you by your healthcare provider, please fill out the following information:

Home # ____
Work # ____
Cell # ____
Email address: ____

I authorize the above named physician to release any and all medical test results or other medical information related to my treatment to:

Please initial your choice(s)

_____ May leave message at work to contact the office.
_____ May leave message on answering machine at home/work/cell to contact the office.
_____May contact me via e-mail
_____ May release medical information to spouse: Name: _________________
_____ May release medical information to parents(s):
Parent: ________________________
_____ May release medical information to designated person
Name: _________________________

I understand this release will be in effect unless changed or revoked by myself either in writing or by completing a new release.

I also understand that super information is not included in this release, i.e., HIV, mental health, drug/alcohol, and sexually transmitted disease information.

I acknowledge that I have received the Premier Plastic Surgery/Acqua Blu Medical Spa & Plastic Surgery Center. Notice of Privacy Practices (“Notice”).

DATE: ____
PATIENT NAME: _____________________________________
ADDRESS: ____
DATE OF BIRTH: ______________
SIGNATURE: ____
(Patient or Authorized Representative)
PRINT NAME: _______________________________________
(Patient or Authorized Representative)

03/09