Aesthetic Plastic & Reconstructive Surgery, S.C.
120 East Ogden, Suite 204, Hinsdale, Il 60521
630-920-9404

Patient Registration Form

Patient Name (Last)____________________________ (First)________________________

Mailing
Address________________________________City______________State______Zip_______

Home Phone (_____)____________________Work Phone(____)_____________________

Cell Phone(___)_________________ Social Security ______________________________

Date of Birth______/_______/______ Age________________ Sex__________________

Marital Status_____________________ Occupation ________________________________

Employer____

Work
Address____

Email_____________________Can we email you to confirm your appointment? Yes No

Emergency Contact____

Phone#________________________________Relationship__________________________

Who may we release medical results to?____

Primary Care Physician/Phone # & Address______________________________________

Referred by (circle one): Newspaper Magazine Phone book Friend Family member
Internet Insurance Company Dr.__________________ Other_______________________

(COMPLETE BELOW FOR INSURANCE COVERED CASES *ONLY* – COSMETIC/SELF PAY DO NOT NEED TO COMPLETE)

Parent or Responsible Party/Subscriber to Insurance Policy (if different from patient)

Name(Last)________________________________(First)____________________(M.I)_____

Address______________________________City________________State___Zip________

Date of Birth____/____/____ Social Sec #__________Employer_____________________

Relationship to Subscriber________________Deductible$__________Copay$_________

Insurance Plan__________________________ID#__________________Group#________

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Privacy Policy & Patient Financial Responsibility

Privacy Policy/HIPAA
I acknowledge understanding of the Physicians Notice of Privacy Practices. (Please sign below) A copy of the Privacy Policy is available upon request.

Patient/ Responsible
Party Signature: x_______________________________________ Date________________

I authorize the release of medical information to my primary care or referring physician, to consultants *if needed and as necessary* to process insurance claims, insurance authorizations or predeterminations, STD/LTD papers, FMLA, third party payer requests and prescriptions. I also authorize payment of medical benefits to Dr. Alexandrina Saulis. Additionally, I hereby authorize the release of my medical records from referring physicians, PCPs, and all other medical institutions that are in possession of medical records that are pertinent to my current medical condition to Dr. Alexandrina Saulis.

I also consent to the use of preoperative, intra-operative and/or post operative photographs for medical purposes deemed appropriate.

Patient/ Responsible
Party Signature: x_______________________________________ Date________________

Patient Financial Responsibility
I acknowledge full financial responsibility for services rendered by Aesthetic Plastic and Reconstructive Surgery. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including deductibles, coinsurances and co-pays. I understand payment of co-pays are expected at the time of service, as well as any prior balance that I may owe prior to procedure or surgery. I also understand that all balances over 60 days will incur a 10% rebilling charge and balances over 90 days are subject to collections proceedings. I agree to all reasonable attorney fees and collection costs in the event of default of payment of my account balance.

Patient/ Responsible
Party Signature: x_______________________________________ Date________________

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Patient Name____

Today's Date___________________ ____

List of Current Medications

Please list all tablets, patches, drops, ointments, injections, etc. Include prescription, over the counter, herbal, vitamins and diet supplements. Also list any medicine that you only take on occasion (i.e. albuterol, flonase, nitroglycerin, etc.)

Medication (Brand or Generic name)	**Dose**	**How and how often do you take the medication**	**Reason for taking**	**Date Started**	**Prescriber (PCP, ER Doc, etc)**

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Health History

Patient Name____________________________**Birthdate**__________________**Age**_________

Today's Date______________________________
Place of Birth______________________________
Marital Status______________________________
Children______________Ages________________
Hobbies___________________________________
Occupation_________________________________
Exercise___________________________________
Who referred you?___________________________
Current Weight_____________Height___________
Email Address_______________________________

Do you Smoke? Yes No If yes, Type_________ Times per wk_____
Do you drink Alcohol? Yes No If yes, Kind__________Times per wk_____
Do you use street drugs? Yes No If yes, Type_________ Times per wk_____
If you are a former smoker, date that you quit____________________________________

Reason for today's visit? ____

Pharmacy you use: ____________________________Telephone #(___)_______________
With regards to test results, may we leave a message at your home telephone?
YES NO
If not, please provide the best phone number where we can leave a message (i.e. cell phone,)__________________________

Allergies to Medications & the reaction you had:_________________________________
____

Please list all medications (prescription and over the counter) including vitamins if not listed on page 3
____

Please list all medical conditions:____

Please list all past surgeries____

____

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Past Medical History

Have you EVER had any of the following?

Heart Disease	Yes	No	AIDS or HIV	Yes	No
Anemia	Yes	No	Mitral Valve Prolapse	Yes	No
Tuberculosis	Yes	No	Hepatitis	Yes	No
Diabetes	Yes	No	Thyroid Disease	Yes	No
Cancer	Yes	No	Bleeding Tendency	Yes	No
MRSA	Yes	No	Any		
High or low blood pressure?	Yes	No	Other disease	Yes	No
Asthma	Yes	No	______________________________		
Emphysema	Yes	No	______________________________		

Have you had any of the following in the last 3 months?

Recent weight changes	Yes	No	Backaches	Yes	No
Skin trouble or changes	Yes	No	Muscle cramps		
Easy bleeding or bruising	Yes	No	or spasms	Yes	No
Contacts or eyeglasses?	Yes	No	Depression	Yes	No
Frequent nosebleeds	Yes	No	Leg cramps	Yes	No
Abdominal cramping	Yes	No	Rectal bleeding	Yes	No
Shortness of breath	Yes	No	Chest pain	Yes	No

Family Medical History

Has any blood relative ever had any of the following?

Cancer	Yes	No	Relationship______________
Tuberculosis	Yes	No	Relationship______________
Diabetes	Yes	No	Relationship______________
Heart Disease	Yes	No	Relationship______________
High Blood Pressure	Yes	No	Relationship______________
Bleeding Tendency	Yes	No	Relationship______________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

Patient
Signature______________________________________Date______________________

Physician
comment:____

Physician
Signature:____________________________________Date_________________________