GROTTING & COHN PLASTIC SURGERY

Patient Information

Date:_____ Social Security #:_____ Date of Birth:_____ Age:_____

Patient's Name:_____ Marital Status: S M W D Sep. Sex: M

Ethnicity: Hispanic____ Non-Hispanic_____ Race: (circle one) African-American Asian Caucasian Hispanic Other_____

Address:_____ City:_____ State:_____ Zip:_____

Home Telephone:_____ Cell #:_____ Work Telephone:_____

Patient's Employer:_____ City:_____ State:_____ Zip:_____

Email Address:_____ Preferred method of contact: _____ Text: Y N

Spouse's/Parent's Name:_____ SS#:_____ Date of Birth:_____

Spouse's Telephone:_____ Cell#:_____ Work Telephone:_____

Spouse's/Parent's Employer:_____ Occupation:_____

Employer's Address:_____ City:_____ State:_____ Zip:_____

Responsible Party Information

Name of Responsible Party:_____ SS#:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Telephone:_____ Cell #:_____ Work #:_____

Responsible Party's Employer:_____ Occupation:_____

Employer's Address:_____ City:_____ State:_____ Zip:_____

Relationship to Patient:_____

Insurance Information

Name of Insurance Co.:_____ Contract #:_____ Group No.:_____

Name of Insured as it Appears on Card:_____ Date of Birth:_____ SS#:_____

Name of Secondary Insurance Co.:_____ Contract #:_____ Group #_____

Name of Insured as it Appears on Card:_____ Date of Birth:_____ SS#:_____

Were You Injured in an Accident? Yes No Date of Accident:_____ State:_____ Type:_____

In Case of Emergency Notify (other than Responsible Party)

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Explanation of Payment Policy and Insurance Filing Procedures

All Insurance Patients – Signature on File

I request that payment of authorized benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services.

Medicare Patients Only – Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

I authorize treatment by Grotting & Cohn Plastic Surgery physicians and personnel. ****Form must be signed and dated by patient or responsible party.**

Patient Signature: _____ ***Date:*** _____

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Name:_____ Date:_____

Referral Source:

Dr._____ Friend/Family: _____Website/Internet:_____Magazine:_____ Other:_____

What issues do you wish to discuss at your consultation?_____

Height:_____ Weight:_____ Ideal Weight:_____ Stable weight for at least a year (within 10-15 lbs) Y N

HABITS:

Smoke: Y N If Yes: _____ packs per day for _____ years. Stopped _____ years ago.
Alcohol: Y N If Yes: Amount _____
Daily Exercise: Y N Recreational Drug Use: Y N Coffee/Tea/Soda : Y N

DRUG ALLERGY?: **Y N** ***List Drug(s) & type of reaction:***_____

_____

LATEX ALLERGY?: **Y N** ***TAPE ALLERGY?:*** **Y N**

Medications: (include prescribed, non prescribed and dosage information)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Regular Aspirin Use: Y N Dosage & Frequency: _____

NSA (Advil, Motrin, Ibuprofen): Y N Dosage & Frequency: _____

Personal Medical History: Have you ever had any of the following? (circle Y or N)

Hypertension:	Y	N	Asthma:	Y	N	Cancer	Y	N
Abnormal Bleeding:	Y	N	Depression:	Y	N	Diabetes	Y	N
Anesthetic Problem:	Y	N	Heart Attack:	Y	N	Mental Illness	Y	N
Heart Disease:	Y	N	Stroke:	Y	N	Abnormal Clotting/DVT:	Y	N
Lung Disease:	Y	N	Tuberculosis:	Y	N	Kidney Disease:	Y	N
Substance Abuse	Y	N	Skin Cancer:	Y	N	Sleep Apnea:	Y	N
Acid Reflux:	Y	N	Anemia:	Y	N	Angina:	Y	N
Hepatitis	Y	N	Other: _____					

Surgical History (Please include the year the operation was performed):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Indicate the type(s) of anesthesia received in the past. List any complications/reactions you experienced:

Local Anesthesia ☐ Complication/Reaction:_____
General Anesthesia ☐ Complication/Reaction:_____
Spinal/Epidural ☐ Complication/Reaction:_____

Family History: Please indicate which relative, if any, has ever experienced or have the following:

Hypertension:		Asthma:		Cancer:	
Abnormal Bleeding:		Depression:		Diabetes:	
Anesthetic Problem:		Heart Attack:		Mental Illness:	
Heart Disease:		Stroke:		Abnormal Clotting/DVT:	
Lung Disease:		Tuberculosis:		Kidney Disease:	
Skin Cancer:		Hepatitis:			

Other: _____

Medical Review of Systems: In the past several months, have you experienced, or do you have: (circle Y or N)

Known kidney problems?	Y	N	Sores on legs or feet?	Y	N
Frequent urinary infections?	Y	N	Known blood clotting?	Y	N
Urination difficulty?	Y	N	Leg pain or swelling?	Y	N
Frequent urination at night?	Y	N	Unusual bleeding or bruising?	Y	N
Known liver problems/hepatitis?	Y	N	Anemia?	Y	N
Trouble eating certain foods?	Y	N	Thyroid problems?	Y	N
Nausea or vomiting?	Y	N	Known hormone problems?	Y	N
Constipation or diarrhea?	Y	N	Arthritis or joint problems?	Y	N
Blood/black stools?	Y	N	Muscle cramps/weakness?	Y	N
Abdominal pain or cramps?	Y	N	Memory problems?	Y	N
Frequent heartburn/indigestion?	Y	N	Dizziness?	Y	N
Stomach ulcers in the past?	Y	N	Hearing or Visual problems?	Y	N
Shortness of breath?	Y	N	Frequent Headaches?	Y	N
Coughing up of phlegm/blood?	Y	N	Rash or hives?	Y	N
Chest pain or tightness?	Y	N	Change in appetite/taste?	Y	N
Fainting spells or passing out?	Y	N	Walking/balance problems?	Y	N
Thumping or racing heart?	Y	N			

Other Problems: If yes, explain: _____

Have you ever received a Transfusion? Y N If yes, explain: _____
Have you ever been tested for HIV? Y N If yes, what year? _____ Test results: Pos Neg
Do you wear: Contact lenses? Y N Eye glasses? Y N Hearing aid? Y N Dentures? Y N

For Women Only:

Number of Pregnancies: ____ Number of Children: ____ Breast Feed? ____ How long? ____ Last Period: ___

Date Last Mammogram: _____ Results: _____ Current Bra Size: _____

Physician Information: (This will allow us to communicate with your medical providers) Please list all that apply.

Type	Name	Phone	Fax	City & State	
Referring Physician					
Primary Care Physicia					Date last visit:
General Surgeon					
Oncologist					

Pharmacy Information: (if applicable, this will also allow us to e-prescribe your prescriptions)

Name: _____ Phone: _____ City: _____ State: _____

Patient Signature: _____ ***Date:*** _____

GROTTING & COHN PLASTIC SURGERY

AKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Grotting & Cohn's **Notice of Privacy Practices**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I also understand that if I request any restriction(s) concerning the use of my personal medical information, that Grotting & Cohn Plastic Surgery may not be able to fulfill my request and that I will be notified if my request is denied.

Signed: _____

Date: _____

If not signed by the patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____

Witness: _____

I authorize Grotting & Cohn Plastic Surgery and its employees to speak with the following person(s) about my health care:

Name	**Relationship**	**Contact #**

May we leave information on your answering machine at home? **Yes** **No**
May we leave information on your voicemail at work? **Yes** **No**
May we leave information on your cell phone? **Yes** **No**

Patient Initials _____

I request the following restrictions concerning the use of my personal medical information:

_____

_____

_____

Patient Initials _____

FOR OFFICE USE ONLY

[ ] Acknowledgement received by _____ on _____.

[ ] Acknowledgement refused by patient. Date _____ Time _____.

[ ] Acknowledgement added to patient's medical record on _____.

Directions to Grotting & Cohn Plastic Surgery

From The Birmingham Airport

Take I-65 South to Hwy 31/280 East Exit. Continue on Hwy 31/280 East taking the Hwy 280 East overpass traveling 6.5 miles (toward Childersburg) until you reach Inverness Center Parkway on the Right. We are in the two-story Building (with the red roof). Hyatt Hotel is located behind our building.

From Atlanta

Take I-20 West to the I-459 interchange. Take I-459 South until Exit #19 (Hwy 280 East). Continue on the ramp at the sign reading Hwy 280 East to Childersburg. Bearing Right onto Hwy 280 East. Continue for approx. 1.9 miles until you reach Inverness Center Parkway on the Right. We are in the two-story building (with the red roof). Hyatt Hotel is located behind our building.

From Chattanooga

Take I-59 South to I-459 interchange. Take I-459 South until Exit #19 (Hwy 280 East). Continue on the ramp at the sign reading Hwy 280 East to Childersburg. Bearing Right onto Hwy 280 East. Continue for approx. 1.9 miles until you reach Inverness Center Parkway on the Right. We are located in the two-story building (with the red roof). Hyatt is located behind our building.

From Huntsville / Nashville

Take I-65 South to the I-20/I-59 interchange. Take I-59 North/I-29 East to the Hwy 31/280 Exit. Follow Hwy 31/280 taking the Hwy 280 East overpass traveling 6.5 miles (toward Childersburg) until you reach Inverness Center Parkway on the Right. We are in the two-story building (with the red roof). Hyatt Hotel is located behind our building.

From Jasper

Take Hwy 78 East to I-59/I-29 interchange. Take I-59 North/I-20 East to the Hwy 31/280 Exit which is just passed the Birmingham Jefferson Civic Center (BJCC). Follow Hwy 31/280 taking the Hwy 280 East overpass traveling 6.5 miles (toward Childersburg) until you reach Inverness Center Parkway on the Right. We are in the two-story building (with the red roof). Hyatt Hotel is located behind our building.

From Montgomery

Take I-65 North to the I-459 interchange. Take I-459 North for approx. 3.7 miles until Exit #19 (Mountain Brook/Childersburg). Take the exit continuing to the Right onto Hwy 280 East for approx. 1.9 miles (toward Childersburg) until you reach Inverness Center Parkway on the Right. We are in the two-story building (with the red roof). Hyatt Hotel is located behind our building.

From Tuscaloosa

Take I-59 North/I-20 East to the I-459 interchange. Take I-459 North until Exit #19 (Mountain Brook/Childersburg) bearing Right onto Hwy 280 East. Continue on Hwy 280 East for approx. 1.9 miles (toward Childersburg) until you reach Inverness Center Parkway on the Right. We are in the two-story building (with the red roof). Hyatt Hotel is located behind our building.

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www.grottingcohnplasticsurgery.com

GROTTING & COHN PLASTIC SURGERY

James C. Grotting, MD **Al B. Cohn, MD**

CONSENT FORM

Please initial each line and sign at the bottom of the page and return to the front desk. Thank You.

_____ I consent to necessary treatment of diagnostic tests/ procedures including drug, medicines, performance of operations and conduct of studies that may be conducted by Dr. Grotting, Dr. Cohn and/or their staff.

_____ I understand that if **I am uninsured or have an insurance that is not accepted** at the practice, that I will be responsible for payment IN FULL at time of service.

_____ I understand that **insurance co pays, deductibles, co-insurance and charges not filed with insurance are due at time of service**. Failure to make payment when requested is a basis for legal action, and the undersigned agrees to pay all cost for collections, including a reasonable fee, and herby waives his/her rights of exemption under the laws of the State of Alabama and any other state.

_____ I understand that **it is my responsibility to know if my insurance requires a referral for any office visit and/or office procedure. It is my responsibility to confirm one is obtained**. I understand medical services may not be rendered without the proper referral on file. If I do not obtain a referral, I am responsible for any charges made to my account.

_____ I understand that **I will be responsible for ANY charges that are not paid by my insurance company**. Not all services are covered, and I understand that it is MY RESPONSIBILITY to know the limits of my coverage and to pay any fees that my insurance company denies.

_____ I understand that **most office procedures may fall under major medical. I will be responsible for paying the deductable and/or coinsurance at the time of service**.

_____ I am aware that the practice has a **Notice of Privacy Practices** that contains a section on Patient Rights. I have been given the opportunity to review this Notice (Effective Date 9/23/13).

_____ I am aware that most standard email and/or text do not provide a secure means of communication. There is some risk that any protected health information contained in email and/or text may be disclosed to, or intercepted by, unauthorized third parties. Use of more secure communications, such as phone or fax is always an alternative that is available to you.

_____ I am aware that I may request restrictions concerning the use of my personal medical information and that my request may not be able to be fulfilled and I will be notified if my request is denied.

_____ Person(s): we may speak with regarding your healthcare: (please list name, relationship, and contact number)

_____

_____

_____

_____ I request restrictions concerning my personal medical information:

_____

_____

_____

Patient Signature _____ **Date** _____