

PATIENT NAME _____ SEX _____ AGE _____
Last First Middle

ADDRESS _____ HOME PHONE _____
Street/Box City State Zip

SOCIAL SECURITY # _____ DATE OF BIRTH _____ CELL PHONE _____

PATIENT'S EMPLOYER _____ EMP. PHONE _____

SPOUSE'S NAME _____ SPOUSE CELL PHONE _____

PARENT/LEGAL GUARDIAN: _____ RELATIONSHIP _____

PRIMARY DOCTOR _____ REFERRED BY _____

PURPOSE OF VISIT _____

INJURY/ONSET DATE _____ WORK RELATED ACCIDENT? YES NO or AUTO? YES NO

IF ACCIDENT, HOW AND WHERE OCCURRED _____

INSURANCE INFORMATION:

INSURANCE _____ SUBSCRIBER _____ DOB _____

POLICY/ID# _____ GROUP # _____ EMP NAME _____

SECOND INS _____ SUBSCRIBER _____ DOB _____

POLICY/ID# _____ GROUP # _____ EMP NAME _____

USE AND DISCLOSURE OF INFORMATION ABOUT YOU

Initial

_____ Spokane Plastic Surgeons, PS may use and disclose information about you and your health to diagnose and treat you, obtain payment for your care, and for its health care business operation. The manner in which Spokane Plastic Surgeons, PS may use information about you is explained in the "*Notice of Privacy Practices*", which has been provided to me.

_____ Spokane Plastic Surgeons, PS may leave a message for the patient(s) regarding appointments and rescheduling.

_____ Spokane Plastic Surgeons, PS may disclose information about patient's care to:

(Print Name and Relationship)

(Print Name and Relationship)

AUTHORIZATION FOR TREATMENT AND FINANCIAL RESPONSIBILITY STATEMENT

I hereby certify that the information given is true and correct to the best of my knowledge. I also hereby authorize Lynn D Derby, MD and Edwin Y Chang, MD to furnish information to my insurance and your insurance carrier, if need arises, concerning illness/treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or dependents. I understand that I am responsible for any amount not covered by the insurance. A photocopy of this release is considered valid as the original.

By signing this document, I certify that I am of lawful age and legally competent to consent to this authorization for treatment.

Signature of Patient

Date of Signature

Signature of Patient Representative/Agent

Relationship to Patient

Patient's Name: _____

Current height: _____ **Current weight:** _____ lbs. **If hand injury:** Right – Left - Bilateral

Blood disorders:	Y	N	Pacemaker/defibrillator	Y	N	Skin:	Y	N
Anemia			Poor circulation			Rashes/Lesions		
Clotting			High cholesterol			Other Health Problems:		
DVT - Deep Vein Thrombosis			Joint disease:					
HIV/AIDS			Arthritis Rheumatoid/DJD					
Nose bleeds			Fibromyalgia			Personal Health & Habits:		
<i>Cancer - Specify</i>			Osteoporosis			Contacts - Eyeglasses		
Endocrine:			Back/neck			Hearing aides		
Diabetes			Lungs:			Dentures uppers/lowers		
Hypoglycemia			Asthma			Smoke # pks/day		
Thyroid			Emphysema/COPD			Tobacco products		
Gastrointestinal/ Bladder:			Shortness of breath			Drug use		
Heartburn/reflux			Sleep apnea/uses CPAP			Alcohol use		
Hepatitis A, B, or C			Snoring			Are You On:		
Kidney failure			Mental/Emotional:			Aspirin 81 mg -325 mg		
Ulcers			ADHD			Coumadin		
Heart:			Depression/anxiety			NSAIDS (Aleve, Motrin, Ibuprofen)		
Chest pain			Mental illness			Steroids		
Heart attack			Neurological:			Other:		
Heart disease/problems or stents			Headaches			Currently Nursing		
Heart murmur			Memory loss			Currently Pregnant # of Pregnancies:		
High/Low blood pressure			Seizure			When Was Last Mammogram?		
Irregular heart beat			Stroke			Personal/Family history of Breast Cancer		

