THE MARTIN CENTER
FACIAL PLASTIC SURGERY • SKIN CARE • LASER CENTER

Patient Registration Form

Legal Name: _____Preferred Name: _____

Date of Birth: _____ Sex: M F Marital Status: S M W Div Sep

Social Security #: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Email Address: _____

Patient's Employer: _____

Work Phone #: _____ Occupation: _____

Work Address: _____

Spouse's Name: _____ Spouse's Employer: _____

Spouse's Occupation: _____ Spouse's Work #: _____

Emergency Contact Information

Emergency Contact Person: _____ Emergency Phone #: _____

Address: _____

Relationship to Patient: _____

Insurance Information

Insurance Company: _____

Policy #: _____ Group #: _____

How did you hear about us? ☐ Friend ☐ Newspaper Ad ☐ Yellow Pages ☐ Internet ☐ TV ☐ Radio

Patient Name: _____ **Date of Birth:** _____
(Please Print)

Pursuant to the information contained in the Notice of Privacy Practices. I give permission for the use and disclosure of Protected Health Information (PHI) in order to carry out Treatment, Payment, and Healthcare Operations (TPO) as provided for below and otherwise in writing. I am aware that I have the right to review the Notice of Privacy Practices prior to signing this consent. Should the Notice of Privacy Practices be revised, I am aware that I may obtain a copy of the revised form by contacting the Medical Director of this facility.

☐ I consent to The Martin Center and/or their agents contacting me by **telephone** (including prerecorded/artificial voice messages, use of automatic dialing device and leaving voice messages, as applicable) to confirm appointments, schedule procedures, discuss billing and payment issues and/or payment arrangements, discuss lab results and other matters which help conduct treatment, payment and healthcare operations. The telephone number(s) to be used for these purposes are _____

☐ I consent to The Martin Center and/or their agents contacting me by **text message** to confirm appointments, schedule procedures, discuss billing and payment issues and/or payment arrangements, discuss lab results and other matters which help conduct treatment, payment and healthcare operations. The telephone number(s) to be used for text messages is/are: _____

☐ I consent to The Martin Center and/or their agents contacting me by **email** to confirm appointments, schedule procedures, discuss statement balances, billing and payment issues and/or payment arrangements, discuss lab results and other matters which help conduct treatment, payment and healthcare operations. The email address to be used for these purposes is: _____

I understand that communications exchanged by telephone, text, or email will not be encrypted, may not be secure and could result in a breach of my PHI and/or a third party obtaining access to my PHI. Notwithstanding these risks, I consent to communications by the methods I have selected above (if any). Further, by requesting or sending any communication to The Martin Center, I give my consent for return communication using the same method used by me regardless of whether it was selected above and/or by any of the methods I have selected above.

This consent is effective until revoked by me in writing except disclosures made in reliance upon my prior consent.

Additionally, I give my permission for release of my PHI to the following people:

_____

_____

Appointment and Financial Policies:

Appointment times are valuable to both patients and staff. Missed appointments cause inconvenience to both. We value your time and ask you to respect us as well. For this reason, we require a 24 hour notice to reschedule or cancel an appointment. If you do not give us the courtesy of a 24 hour notice you will be billed a $25.00 per appointment.

Payments for all cosmetic services are paid in advance. We accept cash, in state checks, and credit cards in your name. For surgical services, payment is due 2 weeks prior to your surgery.

For insurance eligible charges, I directly assign all medical/surgical benefits to The Martin Center and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize The Martin Center to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Any outstanding balance greater than 60 days past due is subject to collection turnover. You will be charged a collection rate of 33.3% of the balance, plus the balance due, plus any legal fees and all court costs associated with any outstanding balance that is turned over to a collection agency. A credit report may be requested for the purpose of collecting any past due balance and your delinquent debt may be reported to any credit bureau.

I have read, understand and agree to the disclosure and policies above.

Signed: _____ **Date:** _____
(Patient or Legal Guardian)

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Patient Questionnaire and Medical History Form

Name: _____ Date: _____

DOB: _____ Height: _____ Weight: _____

Who is your primary physician? _____
May we contact them to discuss your medical history if necessary? Yes No

Please answer all questions below as they relate to you.
(If a question is not applicable to you then put "**NA**" in the answer space.)

Medical Problems: _____

Prior Surgeries/Date of Surgery: _____
(Include cosmetic)

Complications/Anesthetic problems from prior surgery:_____

Family history of medical problems: (Circle) Heart problems/ Bleeding tendencies/ High blood pressure/ Diabetes/ Thyroid problems/ Excessive bruising/ Excessive scarring/ Psychiatric or nerve problems/ Poor or delayed healing.
Other: _____

Allergies and Associated Reactions: _____

Are you allergic to any of the following? (Circle) Latex/Iodine/Shell fish/Soy products/
Egg products/Tape/Suture Material/None of the above. Reaction: _____

Medications/Doses/Frequency: _____
_____

Vitamins/Herbs/Weight Loss Products:_____
(The use of herbs, weight loss products, alcoholic beverages and tobacco products should be discontinued 2 weeks prior to surgery.)

Do you use tobacco? No ___ Yes____ Type _____Amount _____ Prior Use _____

Do you drink alcoholic beverages? No ____ Yes____ What _____ Frequency _____

Have you ever had a drug or alcohol abuse problem? Yes No
Explain:_____

Have you ever been under the care of a psychiatrist? Yes No
Explain: _____

Females Only: Are you pregnant? Yes No (Please Circle)
Are you Nursing? Yes No (Please Circle)

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System Review

(Please answer yes or no to the following as it pertains to you)

General Health

Are you in good health	Yes	No
Any recent weight change	Yes	No
Any problems with healing	Yes	No
Do you bruise easy	Yes	No
Any problems with anemia	Yes	No
Any problems with sleeping	Yes	No
Do you have frequent headaches	Yes	No
Do you exercise regularly	Yes	No
Do you get sick easily	Yes	No

Heart and Lungs

Do you have heart problems	Yes	No
History of chest pain	Yes	No
History of irregular heart beats	Yes	No
Any problems with shortness of breath	Yes	No
History of heart attack	Yes	No
Swelling of feet, ankles or hands	Yes	No
Muscle discomfort with walking	Yes	No
Problems with asthma or wheezing	Yes	No
Do you ever spit up blood	Yes	No

Skin

Problems with skin rashes	Yes	No
Problems with sensitive skin	Yes	No
Any complexion problems	Yes	No
Skin color problems	Yes	No
History of skin cancer	Yes	No
Do you use tanning beds	Yes	No
Do you sun tan frequently	Yes	No

Head and Neck

Do you have visual problems	Yes	No
Any problems with dry eyes	Yes	No
Any problems with double vision	Yes	No
Do you have hearing problems	Yes	No
Nasal breathing problems	Yes	No
History of nasal fracture	Yes	No
History of frequent sinus infections	Yes	No

Gastrointestinal

Loss of appetite	Yes	No
Nausea or vomiting	Yes	No
Heart burn or reflux problems	Yes	No
Liver problems	Yes	No

Musculoskeletal

Joint stiffness, swelling or pain	Yes	No
Weakness of muscles or joints	Yes	No
Any numbness or tingling sensations	Yes	No
Any limited motions	Yes	No

Neurological

Light headed or dizzy	Yes	No
History of stroke	Yes	No
History of paralysis	Yes	No
History of head injury	Yes	No
History of nervous breakdown	Yes	No
Have you ever had a seizure	Yes	No

Endocrine/Immune

Thyroid problems	Yes	No
Excessive thirst or urination	Yes	No
Heat or cold intolerance	Yes	No
Are you HIV positive	Yes	No
Do you have AIDS	Yes	No
Any history of sexually transmitted disease	Yes	No

Dental

Have you ever worn braces	Yes	No
Do you have an overbite	Yes	No
Do you have TMJ problems	Yes	No
Do you snore	Yes	No
Do you have Sleep Apnea	Yes	No
Do you use Nasal CPAP	Yes	No
Do you get fever blisters often	Yes	No

Other

Do you have hay fever or allergies	Yes	No
Any problems with depression	Yes	No
Are you a nervous person	Yes	No
Are you easily upset or irritated	Yes	No
Do you tend to hold “grudges”	Yes	No
Are you afraid of needles	Yes	No
Are you claustrophobic	Yes	No

Do you accept the fact that every medical and surgical treatment is associated with risks and other imponderables?
Yes No _____ (Initial)

Do you accept the fact that the practice of plastic surgery and medicine in general is an imperfect art and science and therefore we cannot guarantee a perfect result with any surgery or treatment? Yes No _____ (Initial)

Please list any other medical problems that have not been covered: _____
_____

Signed: _____ Date: _____

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