PLASTIC, RECONSTRUCTIVE & HAND SURGERY

51 Main Street
Hyannis, MA 02601

Diplomate
American Board of Plastic Surgery

Patient Information & Demographics

Name: _____ **Date of Birth:** ____/____/_____ ❑ **Male** ❑**Female**

Social Security No: _____-_____-_____ **Marital Status:** ❑ **Single** ❑ **Married** ❑ **Divorced** ❑ **Widowed** ❑ **Separated**
(REQUIRED FOR INSURANCE)

Address: _____ **City** _____ **Zip Code** _____

Mailing Address (if different from above): _____❑

Home Tel #: _____ **Cell#:** _____ **Email:** _____

Employer: _____ **Occupation:** _____ **Work #:** _____

Primary Care Physician (full name & town): _____

Emergency Contact: _____ **Relationship:** _____ **Tel #:** _____

The following questions are asked in accordance with government compliance:

Primary Language: _____ **Ethnicity:** ❑ **Hispanic or Latino** ❑ **Non-Hispanic or Latino** ❑ **Patient Declines to Answer**

Race: ❑ **Asian** ❑ **Native American/Alaskan** ❑ **African American/Black** ❑ **Native Hawaiian/Pac. Island** ❑ **Caucasian/White** ❑ **Patient Declines to Answer**

Insurance Information

Primary Insurance Company: _____ Policy No.: _____

Subscriber Name: _____ Subscriber's Social Security No.: _____

Secondary Insurance Company: _____ Policy No.: _____

Subscriber Name: _____ Subscriber's Social Security No.:_____

Is this workman's compensation? Yes (☐) No (☐) **Is this an automobile accident?** Yes (☐) No ☐

Worker's Compensation Company or Attorney: _____

Address: _____

_____

Phone: _____

Signature: _____ **Date** _____

PERSONAL MEDICAL HISTORY (check all that apply)

- ☐ Alcoholism
- ☐ Allergies/Hayfever
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Transfusions
- ☐ CAD
- ☐ Cancer/Type_____
- ☐ Cardiac Pacer
- ☐ Cardiovascular Disease
- ☐ CHF
- ☐ Cirrhosis
- ☐ Colitis
- ☐ COPD
- ☐ CRF
- ☐ Crohn's Disease
- ☐ CVA
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Epilepsy
- ☐ Fracture
- ☐ Gastric Ulcer
- ☐ Gastrointestinal Disease
- ☐ GERD
- ☐ Gestational Diabetes
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Hepatitis/Type_____
- ☐ High Cholesterol
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Joint Pain
- ☐ Kidney Infections
- ☐ Kidney Stone
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Prior MI
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Prior MI
- ☐ Progress Neurological Disorder
- ☐ Pulmonary Disease
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ STD
- ☐ Terminal Illness_____
- ☐ Thyroid Disease
- ☐ TIA
- ☐ Tuberculosis

FAMILY MEDICAL HISTORY (please indicate Mother/Father/Sister/Brother next to all that apply)

☐ No Significant Family History	☐ Congenital Anomaly	☐ Hypertension
☐ Alcoholism	☐ COPD	☐ Hypothyroidism
☐ Anemia	☐ Crohn's Disease	☐ Kidney Disease
☐ Anxiety	☐ Depression	☐ Liver Disease
☐ Asthma	☐ Diabetes	☐ Multiple Births
☐ Birth Defects	☐ Epilepsy	☐ Osteoarthritis
☐ CAD	☐ GERD	☐ Osteoporosis
☐ Cardiovascular Disease	☐ Hypercholesterolemia	☐ Pulmonary Disease
☐ CHF	☐ Hyperlipidemia	☐ Stroke
☐ Cancer/Type	**Mother** ❑ Living ❑ Deceased	**Father** ❑ Living ❑ Deceased

SOCIAL HISTORY (check all that apply)

Smoking status:

- ☐ Never smoked
- ☐ Current every day smoker
  Packs per day? _____ How many years? _____
- ☐ Current occasional smoker
  How often? _____ How many years? _____
- ☐ Former smoker
  Date quit? _____ How often?_____
  How many years?_____

Do you drink alcohol?

- ☐ Non-drinker
- ☐ Occasional
- ☐ Social
- ☐ Moderate
- ☐ Heavy
- ☐ Recovering Alcoholic

Do you consume caffeine?

- ☐ Yes
- ☐ No

*How much?*_____

Height _____

Weight_____

SURGICAL/PROCEDURAL HISTORY (check all that apply)

- ☐ None
- ☐ Appendectomy
- ☐ Breast Lumpectomy Right/Left
- ☐ Cone Biopsy
- ☐ D & C
- ☐ Endometrial Ablation
- ☐ Gall Bladder
- ☐ Heart Surgery
- ☐ Hernia
- ☐ Hysterectomy
- ☐ Laparoscopy
- ☐ Mastectomy Right/Left
- ☐ Myomectomy
- ☐ Oophorectomy Right/Left
- ☐ Tonsillectomy/Adenoidectomy
- ☐ Tubal Ligation
- ☐ Other _____

PREVENTATIVE CARE

Men & Women:

Date of last: EKG _____

Physical Exam _____

Flu vaccination _____

Pneumonia vaccination _____

Women Only:

Number of pregnancies _____

Number of children _____

Date of last mammogram _____

MEDICATION ALLERGIES

	MEDICATION	REACTION
Are you allergic to any medications?	_____	_____
	_____	_____
	_____	_____

Are you allergic to latex? ❑ Yes ❑ No

Are you allergic to adhesive tape? ❑ Yes ❑ No

MEDICATIONS (include prescription & non-prescription)

MEDICATION	DOSAGE	TIMES/DAY

Permission is granted to release pertinent medical information for pending surgical procedure.

_____ _____

Patient Signature Date

CAPE COD PLASTIC SURGERY, INC.
51 MAIN STREET
HYANNIS, MASSACHUSETTS 02601
(508) 771-0290

Marc C. Fater, M.D.F.A.C.S.
American Board of Surgery
American Board of Plastic Surgery

Cosmetic Surgery
Plastic and Reconstructive Surgery
Surgery of the Hand

FINANCIAL RESPONSIBILITY STATEMENT:
I understand that if my insurance company requires a referral, I am responsible for obtaining it. Without said referral, I am financially responsible for all charges incurred. For and in consideration of services rendered, or to be rendered to myself, as a patient of **Cape Cod Plastic Surgery, Inc.,** the undersigned agrees to pay **Cape Cod Plastic Surgery, Inc.,** for all charges incurred. Should the account for changes be referred to a collection agency or to an attorney for collection, I shall pay reasonable collection or attorney fees and court costs as collection expenses.

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF MEDICAL INFORMATION:
I authorize direct payment to **Cape Cod Plastic Surgery, Inc.** for these services at a rate not to exceed **Cape Cod Plastic Surgery, Inc.'s** regular charges. It is agreed that the payment of these benefits to **Cape Cod Plastic Surgery, Inc.** shall not discharge my responsibility to pay for charges not covered by my insurance plan. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize **Cape Cod Plastic Surgery, Inc.** to disclose portions of the patient's record, including medical records, to any person or corporation or governmental agency which is or may be liable for all or any portion of the **Cape Cod Plastic Surgery, Inc.** charges. If payment is to be made under Title XVIII of the Social Security Act, I certify that the information given by me in applying for payment is correct and authorize any owner of medical or other information about me to release to the Social Security Administration or its intermediates or carriers any information needed for this or nay related Medicare claim.

WORKMAN'S COMPENSATION:
If my medical problem is work-related, then I am responsible for obtaining a form from my employer specifying **First Report of Accident/Injury.** To change a claim to Workman's Compensation involves extensive paperwork and a reduction of physician reimbursement. Therefore, I will be responsible for any additional fees incurred for this increased paperwork and reduction of reimbursement in I later change my claim to Workman's Compensation.

_____ _____
Authorized signature **Date**

_____ _____
Insured (if other than patient) **Date**

_____ _____
Witness **Date**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it *Notice of Privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.* I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I UNDERSTAND AND AGREE TO THE ABOVE:

Signature: _____ Date: _____