

Date _____

MINOR PATIENT INFORMATION FORM

Patient Name _____ SS# _____

Address _____ Home Phone(_____) _____ Sex M F

City _____ State _____ Zip _____ Birthdate _____ Age _____

Father _____ Phone _____ Other _____

Address _____ City _____ State _____ Zip _____

Mother _____ Phone _____ Other _____

Address _____ City _____ State _____ Zip _____

If patient is a minor, are parent's divorced? YES _____ NO _____
Who is the patient's legal guardian? Do both parent's share custody of the patient? Please explain.

****If joint legal custody, both parent's consent is required prior to any procedure****

****PRIMARY INSURANCE****

Name _____ Relation to patient _____

Address _____ DOB _____ SS# _____

City _____ State _____ Zip _____ Employer _____

****ADDITIONAL INSURANCE****

Name _____ Relation to patient _____

Address _____ DOB _____ SS# _____

City _____ State _____ Zip _____ Employer _____

****Assignment & Release****

I certify that I, and/or my dependents(s) have insurance with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named physician may use my health care information and disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of parent or guardian

Date

Patient Health History Form
Lincoln Aesthetic & Reconstructive Surgery, P.C.

Name: _____ Date: _____

Directions: Please answer the following questions about your **current and past** medical health. This history will assist your doctor in planning for your care.

1. Medical History (Please check all that apply)			
Heart Conditions:	Neurological Conditions:	Muscle or Skeletal Conditions:	Mouth and Teeth Conditions:
Heart Attack	Epilepsy	Arthritis	Mouth Sores
Chest Pain	Fainting Spells	Rheumatoid	Tooth Decay
Heart Failure	Dizzy Spells	Back or Neck Pain	Chipped Teeth
Heart Disease	Stroke	Stiff Jaw	Loose Teeth
Heart Murmur	Seizures	Numb Arms or Legs	Damaged Teeth
Shortness of Breath	Parkinson's Disease	Tingling Arms or Legs	Full Dentures
Swelling of Ankles	Chronic Headaches	Ulcers on Legs	Partial Dentures
Irregular Heart Beat	Multiple Sclerosis		
Mitral Valve Prolapse	Muscular Dystrophy	Miscellaneous Conditions:	Infectious Diseases:
Rheumatic Fever	Cerebral Palsy	Diabetes	Flu
High Blood Pressure	Paralysis	Thyroid Problems	Measles
Pacemaker	Muscle Weakness	Cancer	Mumps
ICO (implantable)	Neuritis	Mental Illness	Small Pox
Cardioverter Defibril.		Emotional Problems	Tetanus
Lung Conditions:	Urinary Conditions:	Glaucoma	Typhoid
Asthma	Kidney Stones	Hearing Loss	
Emphysema	Chronic Infection	Congenital Conditions	
Bronchitis	Kidney Failure	Attention Deficit	
Chronic Cough	Bladder Infections	Learning Disorders	
Shortness of Breath	Bladder Problems	Eye Problems	
Difficult PM Breathing	Hemodialysis	Skin Problems	
Recent Cold	Peritoneal Dialysis	Chicken Pox	
Sinus Infection	Urine/Kidney Problem	Measles	
Respiratory Infection	Gastrointestinal Conditions:	Mumps	
Tuberculosis	Hiatal Hernia	Mononucleosis	
Blood Conditions:	Ulcers	Eczema	
Anemia	Gallbladder Problems	Gonorrhea	
Bruise Easily	Jaundice	Syphilis	
Bleeding Problems	Hepatitis	Venereal Disease	
Leukemia	Liver Disease	Weight Loss	
Sickle Cell Disease	Colostomy	HIV	
	Stomach Problems	Polio	
	Intestinal Problems	Fever	
	Diverticulosis		
	Pancreatitis		

OVER PLEASE →

2. Height _____ Weight _____
3. List any previous surgeries including dates and procedures: _____

4. Allergies: List any allergies to medications, foods, soaps etc.
Allergy _____ What kind of reaction? _____

5. Will you accept blood transfusions if needed? Yes _____ No _____
6. Have you had previous blood transfusions? Yes _____ No _____ When _____
7. Are you currently pregnant? Yes _____ No _____
Are you breast-feeding? Yes _____ No _____

8. List all medications that you are currently taking including herbal supplements & birth control.

<u>Medication Name</u>	<u>Dose (Mg or ML) how often</u>	<u>Why taking?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. Have you taken any steroid, cortisone or prednisone therapy in the last 12 months?
Yes _____ No _____
10. Have you had radiation therapy? Yes _____ No _____

11. Do you use tobacco or smoke? Yes _____ No _____
If yes, what type? Cigarette _____ Pipe _____ Chew _____
Have you ever previously smoked? Yes _____ No _____
If yes, how many years? _____
How many packs per day of cigarettes did you smoke? _____

12. Do you drink caffeinated beverages? Yes _____ No _____
If yes, amount per day? _____

13. Do you drink alcoholic beverages? Yes _____ No _____
If yes, what type and how many drinks per day? _____
Have you ever been in treatment? Yes _____ No _____

14. Do you use or have you ever used IV or "street" drugs? Yes _____ No _____
If yes, what type and amount? _____

15. Have you previously had anesthesia? Yes _____ No _____
If yes, what typed of anesthesia? General ___ Local ___ Spinal ___ Epidural ___ Other ___
If yes, have you ever had any problems with anesthesia? _____
Have you or a blood relative ever had an allergic reaction or history of complications while under the influence of anesthesia? If so, please explain;

16. Who is your Primary Care Physician? _____

The facts and information that I have given on this form is accurate to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

LINCOLN AESTHETIC & RECONSTRUCTIVE SURGERY

**Mitchell J. Henry, M.D., D.D.S.
Joseph C. Camarata, M.D., D.M.D.
2222 South 16th Street, Suite 300
Lincoln NE 68502
402-435-0044**

PATIENT FEE AGREEMENT

I understand that all professional services rendered are charged to and are the responsibility of the patient. Although Lincoln Aesthetic and Reconstructive Surgery will complete insurance forms to expedite insurance carriers payments, I understand that I am responsible for all fees incurred, including all charges not covered by the insurance carrier for any reason. If my insurance carrier requires by contract a "co-pay" payment to be made by the patient, I will pay that co-pay payment on the day that service is provided.

I understand that it is my responsibility to complete payment in full for services provided within 60 days of the date of service. If after 60 days payment is not made in full, 16% interest per annum will be added to my balance each month until the account is paid in full. This also includes any finance charges that have been added due to an account being delinquent. In the event that I am due a refund, after my insurance company has completed payment; I understand that the refund will be done within 60 days of the date of payment, and that the refund will be given in the manor in which I paid.

Date: _____ Signature of Patient or Guarantor: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Lincoln Aesthetic and Reconstructive Surgery to furnish information to my insurance carrier(s) concerning my illness and treatments. I hereby assign to Lincoln Aesthetic and Reconstructive Surgery, all payments for medical services rendered to my dependent or myself. I understand that I am responsible for all charges for services rendered that are not covered by insurance and I will pay such charges according to the Patient Fee Agreement.

Date: _____ Signature of Patient or Guarantor: _____

MEDICAL RECORDS RELEASE

I hereby authorize Lincoln Aesthetic and Reconstructive Surgery to release any information that may assist in my medical or dental care. This may include medical records such as pathology reports, culture reports, progress notes, x-ray and operative reports. I also give permission for Lincoln Aesthetic and Reconstructive Surgery to discuss my treatment with a physician or dentist in the event that it may be deemed necessary to provide me with medical and dental care. This release also includes release of information to physical or occupational therapy and communication with my therapist.

Date: _____ Signature of Patient or Guarantor: _____

LINCOLN AESTHETIC & RECONSTRUCTIVE SURGERY
2222 SOUTH 16TH STREET SUITE 300
LINCOLN NE 68502

DETAILED NOTICE OF PRIVACY PRACTICES

Changes to this notice - We reserve the right to make changes to this notice of privacy practices. The revised practices will be implemented as of the effective date on the revised notice and will apply to all medical information whether it was collected before or after the date of revision. The revised notice will be posted in our office and copies will be available at the front desk for review.

Complaints - You may file a complaint regarding our policies and procedures or report non-compliance with our policies and procedures to our Privacy Officer at the above address. You may also file a complaint with the Secretary of Health and Human Services. We will not penalize you in any way for filing such a complaint.

If you would like a copy of our privacy practices, requests may be made at the front desk.

If you have any questions about this notice, please contact:

Privacy Officer	Amy Bednar
Practice Name	Lincoln Aesthetic and Reconstructive Surgery, PC
Address	2222 S 16 th Street, Suite 300 Lincoln, NE 68502
Telephone number	402 435-0044
Fax number	402 435-7010

I verify that I have read and understand the privacy practices of Lincoln Aesthetic & Reconstructive Surgery.

Effective Date of Notice: _____

Patient Name: _____

Address: _____

Phone Number: _____

(Signature of patient or guardian)

(Date)