RENAISSANCE

PLASTIC SURGERY, P.C.

PATIENT REGISTRATION

PATIENT INFORMATION

NAME:_______________________________________ DATE: ________________

SOCIAL SECURITY: _____________________________ AGE: ________________

DATE OF BIRTH: ____________ MARITAL STATUS ________ RACE ______ SEX _______

LANGUAGE: PLEASE CIRCLE ENGLISH / OTHER ETHNICITY: PLEASE CIRCLE HISPANIC / NON-HISPANIC

HOME ADDRESS: ____

CITY: __________________ STATE: _______ ZIP: ___________ COUNTY: _____________

HOME PHONE: ______________ WORK: ________________ CELL: __________________

CAN WE CONTACT YOU AND OR LEAVE A MESSAGE AT THESE NUMBERS? ☐ YES ☐ NO

EMAIL ADDRESS: ____

CAN WE SEND CONFIDENTIAL INFORMATION TO YOU? ☐ YES ☐ NO

PATIENT EMPLOYER: __________________________ OCCUPATION: ___________________

ADDRESS: _____________________________________ STATE: ___________ ZIP: ________

PHARMACY: ________________________________ PHONE: __________________________

ADDRESS: ______________________________ CITY, STATE, ZIP: _____________________

INSURANCE INFORMATION

1ST INSURANCE CO: __________________________ INSURED NAME: ___________________

INSURED DATE OF BIRTH: _________ SOCIAL SECURITY: __________ PHONE: __________

2ND INSURANCE CO: _________________________ INSURED NAME: ____________________

INSURED DATE OF BIRTH: _________ SOCIAL SECURITY: __________ PHONE: __________

RESPONSIBLE PARTY

RESPONSIBLE PARTY: ________________________ RELATIONSHIP: __________________

EMERGENCY CONTACT: ____________ PHONE: _____RELATIONSHIP_________________

HOW DID YOU HEAR ABOUT OUR OFFICE? Radio Newspaper Magazine Yellow Pages Internet
Physician _______________________ Friend ______________________ Family ______________________

I hereby authorize payment directly to Renaissance Plastic Surgery, PC and/or Renaissance Surgical Centre', LLC for any surgical and/or medical benefits due. I further authorize release of any information, photographs, and or slides acquired in the course of my examination and/or treatment to recover such payments. I understand that payment is due at the time of service. I understand that I am responsible for ensuring that my insurance is in network with my doctor and it is my responsibility to meet all referral requirements with my insurance company. I further understand and agree that my insurance is filed as a courtesy and that I am ultimately responsible for any balance due after the insurance company has made payment.

_________________________________ _____________________________
PATIENT SIGNATURE DATE

RENAISSANCE

MEDICAL/SURGICAL HISTORY

Patient Name ______________________ Date ______________________

Procedure ______________________

Describe in your own words the reason for your visit to our office. Also, give names of any physician contacted regarding this problem.

____

____

____

____

In this time of rapidly expanding medical knowledge and the increasing specialization associated therewith, there exists a very real risk of specialist physician not being aware of the general health and medical background of the patient. On occasion such information may critically affect what procedures we may safely undertake on you and under what circumstances. We, therefore, ask that you give us the following medical information.

Age:	Height:	Weight:	Occupation:
List all Drug Allergies:			
Do you have an allergy to Latex? □ yes □ no			
Are you a smoker? □ yes □ no Ex-smoker? □ yes □ no Non-smoker? □ yes □ no			
How much are (were) you smoking?	How long?	Quit: how long?	
How much alcohol do you drink?	Caffeine?		
Date of last mammogram:	Circle one: Normal Abnormal		
Please circle all of the following medical conditions you now have or have had in the past:			
Mitral Valve Prolapse / bleeding tendency / hepatitis / diabetes / blood transfusions / glaucoma / dry eyes / lung disease / TB / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / breast cancer / heart attack / stroke / epilepsy / heartburn / intestinal ulcers or bleeding / depression / mental illness / drug or alcohol addiction / cancer / kidney disease / breast disorders / skin cancer / melanoma / high blood pressure / rheumatoid arthritis / scleroderma / lupus / autoimmune disease / unexplained weight loss / chronic fatigue / positive HIV/AIDS test / fever blisters / sleep apnea			
Any possibility that you may be pregnant at this time? □ yes □ no	last cycle		
Number of pregnancies:	Last Tetanus shot:		
Have you had any serious injuries, broken bones, etc.? □ yes □ no			
Have you or anyone in your family had an unusual reaction to anesthesia (muscle weakness, jaundice, breathing problems, or unexpected fever)? □ yes □ no			
Do you have any: (circle one) loose or chipped teeth / dentures / caps / contact lens?			
Have you ever seen a Cardiologist? □ yes □ no			
Name:	Address:		
City: State: Zip:	Date of last EKG:		
Family Physicians Name:	Date of last visit:		
Address:	City: State: Zip:		

MEDICAL/SURGICAL HISTORY

Patient Name ______________________ Date ______________________

List all surgeries that you have had (include plastic surgery):	Date:
______________________	____________
______________________	____________
______________________	____________
______________________	____________
______________________	____________
______________________	____________

Please list all medications which you are currently taking or have used in the past 6 months:

Be sure to list any of the following: birth control, aspirin or ibuprofen containing drugs, Redux Phen-Fen, diabetic medications, steroids, glaucoma drops, asthma medications, Digoxin, Lanoxin, nitroglycerin, Isordil, Inderal, other heart medication, Lasix, other diuretics, high blood pressure medications, Coumadin, Persantine, tranquilizers, anti depressants, pain pills or shots, epilepsy medications.

Medications:	Amount:	Frequency:
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________

Is there any other information we should know about you or your family? □ yes □ no

Please circle all of the following medical conditions that anyone in your family presently or has had in the past:

bleeding tendency / hepatitis / diabetes / blood transfusions / glaucoma / dry eyes / lung disease / TB / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / breast cancer / heart attack / stroke / epilepsy / heartburn / intestinal ulcers or bleeding / depression / mental illness / drug or alcohol addiction / cancer / kidney disease / breast disorders / skin cancer / melanoma / high blood pressure / rheumatoid arthritis / scleroderma / lupus / autoimmune disease / unexplained weight loss / chronic fatigue / mitral valve Prolapse

Family Member:	Alive	Deceased	Age	Cause
Father	□	□		
Mother	□	□		
Siblings	□	□		
Siblings	□	□		
Children	□	□		
Children	□	□		

Patient Signature:
Date:

RENAISSANCE

PLASTIC SURGERY, P.C.

QUESTIONNAIRE

Are you being seen today as a result of an accident? □ yes □ no if yes: _______________date

Please explain: ____

If you were injured on the job, what is the name of the Workers' Comp Insurance?

____

Contact Person: ______________________________ Phone #:_________________________

Please check the areas you would like to discuss today:

_______ Nose
_______ Face Lift
_______ Eyelids
_______ Ears
_______ Chin
_______ Moles/Cysts
_______ Liposuction
_______ Scar Revision
_______ Brow/Forehead Lift
_______ Chemical Peel/Laser
_______ Dermabrasion
_______ Abdominoplasty
_______ Breast Augmentation
_______ Breast Reduction

_______ Hydrafacial (Spa Service)
_______ Skin Care (Spa Service)
_______ Microdermabrasion (Spa Service)

When did you begin to consider surgical corrections? _________________

Have you consulted another physician about this? □ yes □ no

Have you discussed this surgery with your family? □ yes □ no

Are they agreeable? □ yes □ no

Have you had cosmetic or reconstructive surgery? □ yes □ no

Were there complications? □ yes □ no

Did you have a normal recovery? □ yes □ no

Were you satisfied with the results? □ yes □ no

RENAISSANCE

PLASTIC SURGERY, P.C.
SURGICAL CENTRE', LLC

New Patient Consent to the Use and Disclosure of Health Information for Treatment, payment or Healthcare Operations.

I, __________________________, understand that as part of my healthcare, Renaissance Plastic Surgery originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill, provided and,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review of the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Renaissance Plastic Surgery is required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Renaissance Plastic Surgery reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Renaissance Plastic Surgery change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and _____accept_____decline the terms of this consent.

______________________ ___________________

Patient Signature Date

RENAISSANCE

PLASTIC SURGERY, P.C.
SURGICAL OUTCOME DISCLOSURE

In the course of consultation and discussion with my physician, I may have been shown, or may be shown or provided certain brochures, pictures of actual patients, or pictures on an electronic computer imaging device. I do understand that those pictures and alterations of those pictures seen are solely for the purpose of illustration, discussion, and to provide improved communication. I do understand that the outcome of any type of surgical procedure is directly related to my individual characteristics and health. I further understand and acknowledge that because of obvious significant differences in how living tissues react to surgery, there may be no relationship between the electronic images created and my actual surgical results. Use of the computer imaging system offers an opportunity for me to discuss my desires and to allow improved communication with the medical staff.

I certify my understanding that there is no warranty, expressed or suggested, as to my own final appearance after elective surgery by the use of these electronically altered images.

________________________________	___________
Patient Name	Date

Renaissance Plastic Surgery

Patient Photographic Authorization and Release

SURGERY CENTER & SPA
4030 Riverside Park Boulevard
Macon, GA 31210
TEL 478-474-2200
FAX 478-314-0740
E-MAIL khuff@rpsmd.com
www.rpsmd.com

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, ____, consent to the taking of photographs or video of me or parts of my body, by Renaissance Plastic Surgery surgeons or their designee, in connection with plastic surgery procedures to be performed by Renaissance Plastic Surgery surgeons. This will include both "before" and "after" photographs for comparison purposes.

____ ____

Patient Signature *Date*

WITNESS/PHYSICIAN: ____________________________________

I have read the above Authorization and Release. I am the parent, guardian or conservator of ________________________, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

____ ____

Patient/Guardian *Date*

EDUCATIONAL PERMIT

I understand that such photographs, videos or case histories may be published by Renaissance Plastic Surgery surgeons and/or any party acting under their license and authority in any print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods and results.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) years from the date written below.

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Renaissance Plastic Surgery.

I release and discharge Renaissance Plastic Surgery surgeons and all parties acting under their license and authority from all rights that I may have in the photographs, videos or case histories and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these materials in any medium.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

____ ____

Patient Signature *Date*

WITNESS/PHYSICIAN: ____________________________________

I have read the above Authorization and Release. I am the parent, guardian or conservator of ________________________, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

____ ____

Patient/Guardian *Date*

RENAISSANCE

TYLENOL AND/OR EXTRA-STRENGTH TYLENOL IS OKAY TO TAKE.

_______________________________ Patient Name

_______________________________ Date

THE FOLLOWING MEDICATIONS THIN THE BLOOD AND RAISE THE RISKS OF EXCESSIVE BLEEDING DURING AND AFTER THE OPERATION:

ALEVE
ADVIL
ALKA SELTZER
ANACIN
APC
APECTOL
ARTHIRITIS STRENGTH BUFFERIN
ASA COMPOUND
ASCRIPTIN
ASPERGUM
ASPIRIN
BC
BUFF-A-COMP
BUFFERIN
BUTABITAL W/APC
BUTAZOLIDIN
CAPRON CAPSULES
CETASID
CONGESPIRIN
CONTAC
COPE CORICIDIN
CORCIDIN
CORCIDIN D
COUNTERPAIN
DARVON
DEFORTE-DEFULE
DOLOBID
DRISTAN
ECOTRIN
EMPIRIN
EQUAGESIC
EXCEDERIN
EXTRA STRENGTH BUFFERIN
FIORINAL
FISH OIL
FLAXSEED OIL
4-WAY COLD TABLETS
GEMNISYN
GINKO
GOODY'S POWDER
IBUPROFEN
INDOCIN
LIQUIDSRIN TABLETS
MIDOL
MOTRIN
NAPROSYN
NORGESIC
NOVAHISTINE W/APC
PERCODAN
PHENAPHEN
PHENSOL
RELAFEN
ROBAXISAL
SK-65 COMPOUND
STANBACK
SUPAC
SUPER ANAHIST
SYNALGOS
TRIAMINIC
TRIGISIC
VANQUISH
VITAMIN E
ZACTRIN
ZORPHRIN

DO NOT TAKE any of these medications or any medications containing aspirin or blood thinning agents for at least ten (10) days prior to surgery. **PLEASE DO NOT TAKE DIET PILLS OR HERBAL MEDICINES FOR 30 DAYS PRIOR TO SURGERY.**
______ Initials

Please note: this list does not include all medications containing Aspirin! If you are currently taking any medications not listed above, consult with your physician at Renaissance Plastic Surgery, P.C. prior to scheduling surgery. _______ Initials

I have been instructed not to smoke ________ days prior to my surgery. I understand that I will be tested the morning of surgery, and if the test results are positive for nicotine my surgery will be cancelled. ___________ Initials