

North Texas Plastic & Reconstructive Surgery

Please help us to assure you the highest quality care by answering carefully

Legal Name: _____

Mailing Address: _____

Street Address apt # City State zip

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Cell: (____) _____ - _____ Email Address: _____

Sex: M F Age: _____ Date of birth: _____

Last 4 digits of S.S. # _____ DL _____ St _____

Employer: _____ Occupation: _____

Business Address: _____

Marital Status: Single Married Widowed Divorced Other: _____

Name of Spouse: _____ D.O.B. _____

Last 4 digits of S.S. # _____

Employer: _____

Telephone: _____ work/cell: _____

Emergency Contact: _____ Relation to you: _____

Home Phone: _____ Daytime/cell: _____

If patient is under 18 years of age:

Fathers Name: _____ D.O.B. _____

Last 4 digits of S.S. # _____ Employer: _____

Work #: _____

Mothers Name: _____ D.O.B. _____ Last 4 digits of S.S. _____

Employer: _____ Work#: _____

Release of Medical Information & Assignment of Benefits

Office services are to be paid at the time of services rendered. All visits/procedures are to be prepaid unless prior arrangements have been made. As part of your PPO/HMO plans we will be glad to file your insurance, we extend 30 days for coordination of benefits, the balance is due 45 days from the time of service for any coinsurance/deductibles/non-covered services.

I authorize the release of any medical information to process this claim. I also request payment of Government Benefits either to myself or to the party who accepts assignment.

Signed: _____ Date: _____

I authorize payment of medical benefits to North Texas Plastic & Reconstructive Surgery, Charles T. Slack, M.D.

Signed: _____ Date: _____

Patient Name: _____ Date: _____

What is the reason for this visit? _____

How did you hear about our office? _____

Current Medications

Please list all medication(s) and Dosage(s)

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Pharmacy name and location: _____

Pharmacy phone # _____

Do you take any diet medications ? _____ please list _____

Do you use any nonprescription medications/herbal/vitamins?: Yes No

If yes, please list: _____

Name of Personal Physician: _____

Address: _____

Telephone: _____ Fax: _____

Specialty: _____

Drug Allergies and Reactions

Medication(s): _____

What type of reaction(s) did you have: _____

Have you ever had a reaction to: Tape/Latex/Soap(s)/Food(s): _____

If yes, what type of reaction(s) did you have: _____

Family History

Circle any of the following that effect first-degree relatives

- | | | | |
|---------------------|----------------|--------------------|----------|
| High Blood pressure | Heart Disease | Breast Cancer | Diabetes |
| Bleeding disorders | Mental Illness | Hereditary Disease | |

M.D. Initials _____

Patient Name: _____ Date: _____

Medical History

Please check if you have had the following:

- | | |
|--|---|
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Immune disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Irregular heartbeat/palpitations |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Fainting or blackout episodes | <input type="checkbox"/> Lung/respiratory problems |
| <input type="checkbox"/> Heart disease and/or attack | <input type="checkbox"/> Prolonged bleeding when cut |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Heart valve disorder | <input type="checkbox"/> Skin disorders |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Herpes, fever blisters | <input type="checkbox"/> Ulcer Disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> HIV | <input type="checkbox"/> currently seeing Psychiatrist |

If you checked any of the above please explain: _____

Personal Health Habits

Do you now or have you ever smoked, Vaped, or used any other nicotine product including Chewing tobacco? Yes No If yes, How much and how often? _____

Do you drink alcohol? Yes No If Yes, How Often? _____

Height: _____ Weight: _____

Exercise Habits: _____

Date of last menstrual period: ___ / ___ / ___ Are you Pregnant? Yes No

Number of pregnancies: _____ Live births: _____

Date of Last Mammogram: ___ / ___ / ___ What Facility: _____ Results: _____

Surgical History

Please list any surgeries and Dates: _____

Have you or anyone in your family had a reaction to general anesthesia? Yes No

If yes, please explain: _____

Have you formed excessive or unsatisfactory scars in the past? Yes No

If yes, please explain: _____

Have you ever had a blood transfusion? Yes No

If yes, please explain: _____

M.D. Initials _____

North Texas Plastic & Reconstructive Surgery
Limited Patient Authorization for disclosure of Protected Health Information

Patient Name: _____ **DOB:** _____

In our efforts to comply with the health information privacy act, HIPAA, we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Who is authorized to receive information?

Name: _____ relationship: _____ Ph: _____
Name: _____ relationship: _____ Ph: _____
Name: _____ relationship: _____ Ph: _____

Please circle your choice response to the following questions:

May we leave messages on a voice mail at work?	Yes	No
May we leave messages concerning your appointments/treatment with a co-worker, Receptionist, or secretary that regularly answers your calls?	Yes	No
May we leave messages on an answering machine at home?	Yes	No
May we leave information with a spouse or significant other?	Yes	No

Expiration of this Authorization:

This authorization will expire 1 year from the date of your signature below, unless you specify otherwise. You must sign a new authorization after the expiration date to continue authorization. You have the right to terminate this authorization at any time by notifying the Privacy Manager in writing.

Signature: _____ Date: _____

Authorization renewal/changes:

Signature: _____ Date: _____
Signature: _____ Date: _____

Receipt of Notice of Privacy Practices Written Acknowledgment Form

I _____ have been allowed to review/and have been offered a copy of North Texas Plastic and Reconstructive Surgery Privacy Practices.

I _____ have received a copy of North Texas Plastic and Reconstructive Privacy Practices.

Dr. Charles Slack feels obligated to inform you that he has a financial interest in The Texas Health Surgery Center Craig Ranch in McKinney, Texas. He also operates out of the following facilities: Texas Health Presbyterian Hospital of Allen, Methodist Hospital of McKinney, and Baylor Hospital of McKinney

Signature of Patient

Date



Waiver for Use of Text for PHI Information

In order to effectively meet our patients' chosen means of communication, with your consent, North Texas Plastic and Reconstructive Surgery can send appointment and exam confirmations and reminders and other related communications regarding your care and/or your account via text¹.

However, no protected health information (PHI) will be transmitted via text messages without your prior approval. Because public (unencrypted) text messaging is an unsecured form of communication, there is a risk that information contained in text messages may be misdirected, intercepted or improperly disclosed. Therefore, if you desire to receive OR SEND information to/from North Texas Plastic and Reconstructive Surgery, its staff and representatives using text, we require your consent to the following: By signing this Consent Form, I _____ (insert your name) hereby agree to ALL of the following:

- North Texas Plastic and Reconstructive Surgery can send appointment and exam confirmations and reminders and other related communications regarding my care and/or your account via text to the following number: (____) ____-_____
Information and images received by text by North Texas Plastic and Reconstructive Surgery, its staff and representatives will be deleted (after use) from any mobile device(s) on which it was received, and may be printed and/or filed separately as part of your permanent and secure Medical Record.
I accept that I am solely responsible for any information I choose to send to North Texas Plastic and Reconstructive Surgery, its staff and representatives via text, and hereby hold harmless North Texas Plastic and Reconstructive Surgery, its staff and representatives for any and all information/images I send which are improperly received by unauthorized persons.
I understand that texts received by North Texas Plastic and Reconstructive Surgery, its staff and representatives without this waiver being signed by me cannot be accepted or acted upon, and will be deleted immediately.
I retain the right to revoke this consent at any time; however such revocation does not cover messages sent or received in the period of time between the signing of this consent and its revocation. I may revoke this Consent by sending a request in writing to The HIPPA Security Officer, 1105 N. Central Expressway, Suite 370, Texas 75013.

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT FORM AND CONSENT AND AGREE TO ITS TERMS. I UNDERSTAND THAT TREATMENT IS NOT CONDITIONED ON MY SIGNING THIS CONSENT. I AM THE PATIENT OR AM PROPERLY AUTHORIZED TO ACT ON BEHALF OF THE PATIENT.

Date: _____

Signature of Patient

Signature of Person Signing on Behalf of Patient*

Please Print Patient's Name

Please Print Authorized Representative's Name

* Representative's relationship to Patient:

For Office Use Only:

Declined to Sign ___ Logged in System
Employee's
Initials _____ Date

1 Applicable fees remain your responsibility.

INSURANCE AGREEMENT

Patient Name: _____ Date: _____

_____ I understand if I request a pre-determination letter to be sent to my
Please initial insurance company a claim will be submitted to the insurance
company for the consultation and I am responsible for the
co- payment/or co-insurance whether the insurance company
approves the procedure or not.

_____ I am being treated for a cosmetic procedure; I understand insurance
Please initial will not be billed.

Signature: _____

North Texas Plastic & Reconstructive Surgery
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