SULE PLASTIC SURGERY
Facial Plastic and Cosmetic Surgery
12221 Merit Drive • Suite 1060 • Dallas, Texas 75251

Date: _____

Name: _____ Best Contact Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Date Of Birth: _____/_____/_____ SSN: _____-_____-_____ Driver's License #:_____

Alternate phone #: _____ Email: _____

Primary Insurance: _____ PPO/HMO/EPO/POS/Choice Plus

Insurance ID#: _____ Group #: _____

Group policy from employer? Y N Government Exchange Market Place Policy? Y N

Name of Employer: _____ Employer Phone #: _____
Relationship to policy holder? Self/Spouse/Child/Dependent

Policy Holder Name: _____ Policy Holder DOB: _____/_____/_____

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Secondary Insurance: _____ PPO/HMO/EPO/POS/Choice Plus

Insurance ID#: _____ Group #: _____

Group policy from employer? Y N Government Exchange Market Place Policy? Y N

Name of Employer: _____ Employer Phone #: _____
Relationship to policy holder? Self/Spouse/Child/Dependent

Policy Holder Name: _____ Policy Holder DOB: _____/_____/_____

Responsible Party Name: _____ Date of Birth: _____/_____/_____
Address: _____Phone: _____
Relationship: _____

Work Related Injury? Y N Auto Accident? Y N
Date of Injury? _____ Date of Accident? _____
Describe injury briefly: _____
_____

Pharmacy Name: _____ Pharmacy Phone: _____

****

Emergency Contact Name: _____ Relationship: _____

Phone #: _____

****

Persons authorized to discuss my protected medical information and receive copies of my medical history and records:

_____

Name Relationship Date

_____

Name Relationship Date

How were you referred to Dr. Sule?

Primary Care Physician: _____ Phone #: _____

Existing Patient? Y N Friend: _____Other?____Magazine ____Internet _____T.V. ____Staff

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INSURANCE AGREEMENT AND ACKNOWLEDGEMENT:

_____INITIAL I understand that I am financially responsible for charges not paid by my medical insurance and agree to pay the charges. I authorize any holder of medical information about me to release to any responsible health carrier, Texas Department of Insurance and/or Social Security Administration or its intermediaries, any information for this or any related medical claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or The Sule Facial Plastic Surgery Clinic MD PA (E.N.T.)

_____INITIAL Fees for all services performed are determined by Dr. S. Sule alone. These fees are non-negotiable under any circumstances, by any party and payment must be received at the time of service. We will not barter nor accept products or services in exchange for surgery or treatments. Should a balance appear on your account after the date of service for any reason, you will be notified and required to pay those charges within 90 days of the notice. If after 90 days payment has not been received, your account will be reviewed and sent to an outside collection agency. In the event a check is written for services rendered and does not clear your bank account, your balance will then be reinstated and a $50.00 Non-Sufficient Funds Fee will be added.

_____INITIAL RECEIPT OF HIPAA PRIVACY NOTICE AND PATIENT NOTICES. I have received and reviewed a copy of Dr. S. Sule's HIPAA privacy notice and patient notice.

I have read and understand the above policies. I understand that all fees paid are nonrefundable unless deemed medically necessary by Dr. S Sule. Proof of medical condition must be supplied to provide evidence of medical necessity and refund consideration. **(Forms of payment: Cash, Visa, MasterCard, American Express and Discover. NO CHECKS.)**

NOTICE TO ALL INSURANCE PATIENTS

Your insurance policy has specific rules you must follow in order to avoid liability for full payment on services rendered. As a courtesy, we participate in many HMO and PPO plans. It is the patient's responsibility to know your plan benefits, terms and requirements regarding authorized referrals. Our office cannot be held responsible for obtaining initial or extending expired authorized referrals.

_____INITIAL I understand and agree that if medical services are rendered by Dr. Sule to myself while not having a current authorized referral, I will be fully responsible for any charges denied by my insurance plan.

Signature: _____ Date: _____

Printed Name: _____

HISTORY AND MEDICAL INFORMATION

Patient Name: _____ Date: _____

Date of Birth: _____/_____/_____ Sex: Male/Female Height: _____ Weight: _____

Reason for Consultation: _____

****

Allergies/Reaction: _____

Drug Allergies/Reaction: _____

Currently taking Blood Thinners/Aspirin on a regular basis? _____Yes _____No Bruise easily? _____Yes_____No

Have you ever had a reaction to injections of Local Anesthesia? _____Yes _____No

Do you become nauseated after General Anesthesia? _____Yes _____No

Do you become lightheaded or nauseated at the site of needles or injections? _____Yes _____No

Date of last physical: _____ Date of last EKG: _____

Physicians who care for you on a regular basis:

Physician: _____Specialty: _____Last Exam: _____

Physician: _____Specialty: _____Last Exam: _____

Physician: _____Specialty: _____Last Exam: _____

Please circle any medical conditions that may apply to you:

Cancer	Yes / No	Anemia	Yes / No	Alcoholism	Yes / No
Eye Problems	Yes / No	High Blood Pressure	Yes / No	Low Blood Pressure	Yes / No
Heart Disease	Yes / No	Angina	Yes / No	Anemia (unknown cause)	Yes / No
Clotting Disorder	Yes / No	HIV infection (a symptomatic)	Yes / No	AIDS	Yes / No
Stroke	Yes / No	Heart Attack	Yes / No	Congestive Heart Failure	Yes / No
Pacemaker	Yes / No	Neurological Disorders	Yes / No	Depression	Yes / No
COPD	Yes / No	Cold sores/Fever Blisters	Yes / No	Ulcers	Yes / No
Diabetes	Yes / No	Psychiatric Disorder	Yes / No	Rheumatic Fever	Yes / No
Asthma	Yes / No	Emphysema	Yes / No	Lung Disease	Yes / No
Tuberculosis	Yes / No	Thyroid Disease	Yes / No	Renal failure	Yes / No
Hepatitis	Yes / No	Elevated Blood Cholesterol	Yes / No		

CURRENT MEDICATIONS

Medication Name	Dosage/MG	Frequency/How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vitamins or Supplements: _____ Vitamin E? _____Yes _____No

Other or recreational drugs not prescribed by physician and not over the counter? _____

SURGICAL HISTORY

Please list any prior major medical illness or injuries:

_____

_____

Please list any prior surgical history:

Surgery/Hospitalization	**Year**	**Outcome**	**Physician**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any type of implants, facial or body? _____ Yes _____ No

What type? _____ Date/Year: _____

FAMILY HISTORY

Do you have any family history of allergic reactions to anesthesia?	_____ Yes	_____ No
Do you have any family history of bleeding or clotting disorders?	_____ Yes	_____ No
Do you sunburn easily?	_____ Yes	_____ No
Do you have any family history of skin cancer?	_____ Yes	_____ No
Do you have any family history of heart disease?	_____ Yes	_____ No

I certify that the information provided on this medical history is correct and complete. Further, I understand that providing incomplete and incorrect information may not only jeopardize my health but also render ineffective or harmful, any treatment I receive from Dr. S. Sule.

_____ _____

Patient Signature Date

_____ _____

Witness Date

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to disclose my protected health information to carry out:

*Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)

*Obtaining payment from third party payers (e.g. my insurance company);

*The day to day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions.

However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ _____

Patient Signature Date