NIRVANA PLASTIC SURGERY, PA
MEDICAL /HISTORY REGISTRATION FORM

Date: _______________ Sex M☐ F☐

Patient Name:_______________________________________

Address: ____

City: ________________ State: ______ Zip: _____________

DOB:_______________ SS#: __________________________

PH#: ____________________ Cell: ____________________
May we leave a message? ☐ Yes ☐ No
Email address: ___________________________________

Name of Employer: _________________________________

☐Married ☐ Single ☐ Divorced ☐ Widowed

Spouse Name: _________________________________

In Case of Emergency, Contact:
Name: ____

Home Ph#: ____

Cell: ____________________ Work: ___________________

How Did you hear about us? __________________________

Insurance Information
Insurance Co: ____

Policy#: ____________________GP#: ____________________

PH#: ____

Name of Insured: _____________________________________

Relationship to Patient: ________________________________

DOB:__________________ SS#: ________________________

Secondary Insurance: _________________________________

Policy#: _____________________ GP#: ___________________

PH#:____

Name of Insured: ____________________________________

DOB: ______________ ___SS#: _________________________

Who is Responsible for this account?

____
Signature

Insurance Assignment And Release

I certify that I have insurance coverage with __________________________________ and assign direct payment to **Nirvana Plastic Surgery, PA** for insurance benefits on 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 practice may use my health care information and may disclose such information to the above-named insurance company(ies), its agents, and other entities for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.
Medicare Authorization
I request that payment of authorized Medicare benefits and, if applicable Medigap benefits, be made on my behalf to **Nirvana Plastic Surgery, PA** for service furnished to me by that provider.

____ _______________________
Signature of Patient, Parent or Guardian **Date**

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PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY:

General

☐ Chills
☐ Depression
☐ Stress
☐ Dizziness/Fainting
☐ Fever
☐ Headaches
☐ Loss of Sleep
☐ Numbness
☐ Sweats
☐ Seasonal Allergies
☐ Any complications with sexual function

Muscle/Joint/Bone Pain, weakness, numbness

☐ Arm ☐ Hips
☐ Back ☐ Legs
☐ Feet ☐ Neck
☐ Hands ☐ Shoulders

Genito-Urinary

☐ Blood in urine
☐ Frequent urination
☐ Lack of bladder control
☐ Painful urination
☐ Kidney Stones

Gastrointestinal

☐ Poor Appetite
☐ Bloating
☐ Bowel Changes
☐ Constipation
☐ Diarrhea
☐ Excessive thirst
☐ Gas
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Rectal bleeding
☐ Stomach pain
☐ Vomiting
☐ Vomiting blood

Cardiovascular/Lungs

☐ Chest pain
☐ High ☐ Low blood pressure
☐ Irregular/rapid heart beat
☐ Poor circulation
☐ Swelling of ankles
☐ Varicose veins
☐ Coughing
☐ Wheezing

Eyes,Ears,Nose, Throat

☐ Bleeding gums
☐ Blurred vision
☐ Crossed eyes
☐ Difficulty swallowing
☐ Earache/Ear discharge
☐ Hay fever
☐ Loss of hearing
☐ Nosebleeds
☐ Persistent cough
☐ Ringing in ears
☐ Sinus problems
☐ Vision- Flashes/Haloes

Skin

☐ Bruise easily
☐ Hives
☐ Itching/Rash
☐ Change in moles
☐ Scars
☐ Sore that won't heal
☐ Keloids

Women Only

☐ Abnormal pap smear
☐ Bleeding between periods
☐ Breast Lump
☐ Extreme menstrual pain
☐ Nipple discharge
☐ Other___________________

Date of last menstrual period

____

Date of last Pap smear

____

Date of last mammogram:_____________

Abnormal Mammogram Results:

☐ Yes ☐ No

Where was your Mammogram performed? ________________

Are you Pregnant?

☐ Yes ☐ No

Check conditions you have or have had in the past

☐ AIDS
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Breast Lump
☐ Cancer
☐ Cataracts
☐ COPD
☐ Intestinal Disease
☐ Heart Attack
☐ Diabetes
☐ Chemical Dependency
☐ Chicken Pox
☐ Emphysema
☐ Epilepsy
☐ Heart Disease
☐ Hepatitis
 ☐ A ☐ B ☐ C
☐ Herpes
☐ High Cholesterol
☐ Gall Bladder Disease
☐ Pace Maker
☐ HIV Positive
☐ Kidney Disease
☐ Liver Disease
☐ Measles
☐ Migraine Headache
☐ Multiple Sclerosis
☐ Mumps
☐ Ulcers
☐ Lupus or Other Connective Tissue Disease
☐ Pneumonia
☐ Polio
☐ Prostate Problem
☐ Rheumatic Fever
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Veneral Disease
☐ Bleeding Disorders/ Clotting Disorder (IE: Factor V Leiden, Von Willebrand Disease)

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FAMILY HISTORY

Date of last Physical Exam: _________ **Primary Physicians Name: ________________** **Physicians Ph #:_______________**

Father ☐ Deceased ☐ Alive **Mother** ☐ Deceased ☐ Alive **Siblings** ☐ Deceased ☐ Alive

Cause of Death: ____________ Cause of Death: ____________ Cause of Death: ____________
Other family history: (Distant Relatives): ____

Please list any surgeries you have had: ____
____

HAVE YOU EVER EXPERIENCED ANY REACTION FROM ANESTHESIA: ☐ Yes ☐ No
If yes, Please Explain: ____

Medication/ Allergies

List medications you are currently taking: (or you may provide a list)
____
____
____

Pharmacy Name: _______________________ Street, City: ____________________ Ph#: ______________________
Are you allergic to any medications or substances?
____

____

Health Habits

Check which ones you use and how much:

☐ Caffeine: ______________________ ☐ Tobacco: ____________________ ☐ Alcohol: ___________________

☐ Street drugs: ___________________ ☐ Other: ______________________ ☐ Exercise: __________________

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in my/child health or insurance information.

____ __________________________

Signature of Patient, Parent or Guardian **Date**

____
Relationship to Patient

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MISSED APPOINTMENT/LATE CANCELLATION POLICY

We would like to thank you for choosing us your provider of medical and aesthetic services. In order to give you and all of our patients, the best possible care/service, we request that you review our policy regarding missed appointments and late cancellations. **A missed appointment is when you fail to show up for an allotted appointment time, without a phone call. A late cancellation is when you fail to give a notice of at least 24 hours prior to your scheduled appointment time.** Please remember that we have reserved appointment times to accommodate your schedule. Therefore, we respectfully request at a 24-hour notice in order to reschedule your appointment. This will enable us to offer your cancelled appointment time to other patients.

If you are unable to keep your scheduled appointment time, please contact our office at (843)839-2004 at least 24-hours in advance in order to avoid a missed appointment/late cancellation fee. This charge is not covered by your insurance carrier. If you fail to give us notice of your missed appointment or you cancel with less than a 24-hour advance notice, you will be charged a $50 missed appointment/late cancellation fee.

I have read and understand the policy stated above.

____ ____________________

Signature Date

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Acknowledgement of Receipt of Notice of Privacy Practices

(You May Refuse to Sign this Acknowledgement)

I, ________________________________, have received a copy of this office's Notice of Privacy Practices.

____

Please Print Name

____

Signature

____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communication barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other specified reason ____
  ____

_______________________________ _______________________

Employee Signature Date