

# Patient Registration

Date: \_\_\_\_\_ \*Account #: \_\_\_\_\_

Referred By: \_\_\_\_\_

Would you like to be added to our mailing list? Yes \_\_\_\_\_ No Thanks \_\_\_\_\_

Patient's Full Name: \_\_\_\_\_

S.S. #: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Circle One: F M

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Email Address: \_\_\_\_\_ D.L. No.: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

## **Employment:** (if minor, responsible parties)

Employed By: \_\_\_\_\_

Position: \_\_\_\_\_ May we call you at work? \_\_\_\_\_

Address: \_\_\_\_\_

## **Marital Status:**

Circle one: Married Single Separated Divorced Widowed

Spouse's Name: \_\_\_\_\_ S.S. #: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

## **In case of emergency:**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Second Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_



I understand that I am financially responsible for all charges. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, money orders and all major credit cards.

Signed: \_\_\_\_\_

# Health History Form

Dr. \_\_\_\_\_

Name	Date
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Address \_\_\_\_\_

D.O.B.	Age	Height	Weight	Home Phone	Work Phone
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Reason for visit today? \_\_\_\_\_

**Past/Current Hx (Check all applicable)**

<input type="checkbox"/> Lung Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Keloids	<input type="checkbox"/> Abnormal or Excessive Bleeding
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> MRSA	<input type="checkbox"/> Taken Accutane with in Past Year
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> HIV	<input type="checkbox"/> Fever Blisters	<input type="checkbox"/> Neck Problems
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Use CPAP/BPAP				

**Other Major Illnesses:** \_\_\_\_\_

Medications:	Reason for Taking	Frequency/Dose

Do you take ANY Diet Pills, Natural Herbs or Health Food Supplements? If Yes, What: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies and Reactions to Medication? \_\_\_\_\_

\_\_\_\_\_

Previous Surgeries: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you or anyone in your family had complications from anesthesia? If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has anyone in your family had breast cancer before the age of 50? If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you been on ANY steroids in the last year? If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Do you take aspirin on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have excessive bleeding or bruising? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any teeth that are: <input type="checkbox"/> Loose <input type="checkbox"/> Fragile
Do you use any Tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Capped <input type="checkbox"/> False

Signature	Date
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# PHOTOGRAPH CONSENT FORM

I, the undersigned, hereby authorize **John L. Burns, M.D.** to take my pre-photos for planning purposes, medical evaluation, surgical or other procedures and subsequent treatment. **Your photos will not be used in any publication or on the internet without your consent. I herein relinquish any right, title or interest in such photographs and I understand that my identity will not be revealed by the pictures or by the descriptive text accompanying any such photographs.**

## PERSON PHOTOGRAPHED:

Please **PRINT** your name: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

WITNESS (print): \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Requested by: JOHN L. BURNS, M.D.  
Dallas Plastic Surgery Institute, P.A.  
9101 N. Central Expy., Suite 600  
Dallas, Texas 75231  
214-515-0002

# DALLAS PLASTIC SURGERY INSTITUTE

## Patient Consent and Acknowledgment of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Dallas Plastic Surgery Institute creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must agree to any restriction on the use and disclosure of my Protected Health Information that I request in writing, and, when I request in writing, agree to terminate any restrictions on the use and disclosure of my Protected Health Information which have been previously agreed upon.

\_\_\_\_\_  
(PATIENT'S NAME PRINTED)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)

\_\_\_\_\_  
SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)

\_\_\_\_\_  
WITNESS (optional)

\_\_\_\_\_  
DATE

# DALLAS PLASTIC SURGERY INSTITUTE

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### **Protecting your privacy**

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At Dallas Plastic Surgery Institute (hereafter referred to as "the Practice"), privacy is one of our highest priorities.

### **Keeping your information**

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

### **Working to meet your needs through information**

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide service to you, to process your claims and to bring you health information that might be of interest to you.

### **Keeping information accurate**

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us at the telephone numbers or addresses listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

### **How - and why - information is shared**

We limit who receives information and what type of information is shared.

- *Sharing information within the Practice.* We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.
- *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.
- *Other.* Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

### **Count on our commitment to your privacy**

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us-whether it's at our office, over the phone or through the Internet.