BAYLOR COLLEGE OF MEDICINE
DIVISION OF PLASTIC SURGERY (DIVISIÓN DE CIRUGIA PLÁSTICA)

Patient Information Form (Forma De Registración Del Paciente)

PLEASE FILL IN ALL BLANKS:
POR FAVOR LLENAR TODOS LOS ESPACIOS:

Date (Fecha) ________ Physician (Médico) ________

______ New (Nuevo) ______ Update (Poner al día) ________

Patient Data (Datos del Paciente)

Patient Name (Last, first, middle) (Nombre del paciente-Apellido, nombre, segundo nombre)	**Reason for Consultation** (Razón de la Consulta)

Address (Dirección)	**City** (Ciudad)	**State** (Estado)	**Zip Code** (Código Postal)

Home Telephone (Teléfono de Casa)	**Marital status** (Estado Matrimonial)	**Age** (Edad)	**Date of Birth** (Fecha de Nacimiento)	**Sex:** (M or F)	**Social Security #** (Número Social)

Mobile phone number (Número de teléfono celular)	**Email** correo electrónico	**Pharmacy phone number** (Número de teléfono de la Farmacia)

Employer (Patrón)	**Occupation** (Profesión)	**Work Telephone** (Teléfono de Trabajo)

Spouse's Name (Nombre del cónyuge)	**Work Telephone** (Teléfono de Trabajo)	**Spouse's Employer** (Patrón del Esposo/a)

In Case of Emergency (Person not living with patient)	En Caso de Emergencia (Persona que no vive con usted)	**Relationship** (Relación)	**Home Telephone** (Teléfono de Casa)

Person Responsible for Bill (Persona Responsable por la Factura)	**Address** (Dirección)

Telephone (Teléfono)	**City** (Ciudad)	**State** (Estado)	**Zip Code** (Código Postal)

Relationship of patient to responsable party
❑ self ❑ spouse ❑ child ❑ other

Relación del paciente al fiador
❑ usted ❑ esposo/a ❑ hijo/a ❑ otra relación

Referring Source (Fuente de Referencia)
❑ Physician (Name) (Nombre del Médico) ❑ Other (Please Specify) (Otro – Favor de ser Específico)

Insurance (Seguro)

PRIMARY Insurance Company (Compania PRINCIPAL de Aseguranza)	**Telephone** (Teléfono)

Address (Dirección)	**City** (Ciudad)	**State** (Estado)	**Zip Code** (Código Postal)

Group Name (Nombre del Grupo) **Employer Name**	**Group Number** (Número de Grupo)	**Certificate of Policy Number** (Número de Certificado o de Poliza)	**Plan Number** (Número del Plan)

Insured's Name (Nombre del Asegurado)	**Date of Birth of Insured** (Fecha de Nacimiento del Asegurado)	**Insured's Social Security Number** (Número Social del Asegurado)	**Sex of Insured** (M or F) (Sexo del Asegurado H o M)

Relationship of Patient to Guarantor
❑ self ❑ spouse ❑ child ❑ other

Relación del paciente al fiador
❑ usted ❑ esposo/a ❑ hijo/a ❑ otra relación

SECONDARY Insurance Company (Compania SECUNDARIA De Aseguranza)	**Telephone** (Teléfono)

Address (Dirección)	**City** (Ciudad)	**State** (Estado)	**Zip Code** (Código Postal)

Group Name (Nombre del Grupo)	**Group Number** (Número de Grupo)	**Certificate of Policy Number** (Número de Certificado o de Poliza)	**Plan Number** (Número del Plan)

Insured's Name (Nombre del Asegurado)	**Date of Birth of Insured** (Fecha de Nacimiento del Asegurado)	**Insured's Social Security Number** (Número Social del Asegurado)	**Sex of Insured**

Relationship of Patient to Guarantor
❑ self ❑ spouse ❑ child ❑ other

Relación del paciente al fiador
❑ usted ❑ esposo/a ❑ hijo/a ❑ otra relación

Is pre-certification required? (¿Es requirida la pre-certificación?)	**(Primary) Pre-certification Telephone #**	**(Secondary) Pre-certification #**
Yes ❑ No ❑		

Is the charge related to employment_____
auto accident_____
other accident_____

TO PATIENT: INSURANCE WILL NOT BE FILED THROUGH OUR OFFICE UNLESS SIGNED.
AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS
I hereby authorize any physician who has treated or attended me or my dependent to furnish any medical information requested.
In consideration of services rendered, I hereby transfer and assign to the Division of Plastic Surgery for the benefit of the doctors in the Division of Plastic Surgery, Baylor College of Medicine who have treated me or my dependents, any benefits of Insurance that I may have. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that this authorization does not release me from my personal obligation for all charges incurred.

PARA EL PACIENTE: LA ASEGURANZA NO SERÁ REGISTRADA POR MEDIO DE NUESTRA OFICINA SINO ESTÁ FIRMADA
AUTORIZACIÓN PARA RELEVAR INFORMACIÓN Y PARA PAGAR BENEFICIOS
Yo, por la presente, autorizo a cualquier médico que me ha tratado o atendido a mi o mi dependiente que provee cualquier información medica que sea requerida. En consideración de los servicios rendidos, yo por la presente traslado y asigno a la División de Cirugía Plástica por los beneficios de los doctores en la División de Cirugía Plástica, Baylor College of Medicine, quien me han tratado a mi y a mi dependiente, cualquier beneficio de aseguranza que pueda tener. Una fotocopia de esta autorización será considerada tan efectiva y valida como la original. Esta autorización no me releva de mis obligaciones personales para todas las cuentas incurridas.

Signed (Firma): ________________________________

HISTORY AND PHYSICAL

Thank you for being as detailed as possible with this important medical information that will assist us with your care.

FULL NAME:	AGE:
WEIGHT: *LBS*	HEIGHT:
REASON FOR VISIT:	

PAST MEDICAL HISTORY (Please check all that apply)	Diabetes	History of Stroke	Seizures	Hepatitis	Psychiatric illness	HIV+	Asthma	Breast Cancer	Arthritis	Hx of Hyper or Hypo Thyroid	High Blood Pressure	Reflux/GERD	Coronary Artery Disease	Blood Clot Disorder	Chronic Obstructive Pulmonary Disease	Peripheral Vascular Disease		

Please describe any other medical condition for which you are being treated:

PREVIOUS SURGERIES	DATE OF PROCEDURE

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING:

Name Dose Frequency

____
____
____
____
____

ALLERGIES	REACTION: *(rash, dizziness, headache, etc)*

FAMILY HISTORY *(Please check appropriate box)* RELATIONSHIP	*Anesthesia Problems*	*Angina*	*Arthritis*	*Blood Clots*	*Breast Cancer*	*Cervical Cancer*	*Colon Cancer*	*Depression*	*Diabetes*	*Heart Disease*	*High Cholesterol*	*Hypertension*	*Liver Disease*	*Lung Cancer*	*Melanoma*	*Weight Disorder*	*Ovarian Cancer*	*Stroke*	*Thyroid*

SOCIAL HISTORY *(PLEASE CHECK ALL THAT APPLY)*	YES	NEVER	QUIT	DATE YOU QUIT	TYPE	AMOUNT PER DAY	AMOUNT PER WEEK	How many Years ?	COMMENT:
ALCOHOL									
TOBACCO									
DRUG USE									
EXERCISE									

REVIEW OF SYSTEMS

HAVE YOU RECENTLY OR DO YOU COMMONLY EXPERIENCE ANY OF THE FOLLOWING:

Please circle

Anesthesia Problems	Fainting/Dizziness	Jaundice	Hernia	Depression/Anxiety	Nausea/Vomiting	Breast tenderness	Skin or Breast Mass	Abnormal Mouth	Ear, Nose, Throat problems	MRSA	Hemorrhoids	H1N1				
Wt. Loss/Gain	Fever/Chills	*Arthritis*	Cough	Shortness of Breath	Palpitations	Chest Pain	*Urinary Symptoms*	Change in Bowel Habit	Abdominal Pain	Heartburn	*Bleeding*	Indigestion				

Center *for* Aesthetic Surgery
at Baylor College *of* Medicine

DIVISION OF PLASTIC SURGERY

OFFICE POLICY ON INSURED PATIENTS

Many carriers require certain prerequisites such as the pre-certification of a particular procedure. Within the same insurance company the plans differ depending upon what type of contract your employer has negotiated. We are more than willing to follow any and all necessary guidelines to ensure that your encounter with The Division of Plastic Surgery is reimbursed properly, but you must inform us of those guidelines.

Unfortunately, if you do not inform us of any special requirement in your contract and we subsequently order services, such as lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility. This will hold true for any Managed Care contract as well as any group/individual policies which may cover you and your dependents.
With your cooperation and assistance, you should be able to receive all of the benefits offered to you.

I have read and understand the office policy stated above and agree to accept responsibility as described.

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____ ____________________

Signature Date

Center *for* Aesthetic Surgery
at Baylor College *of* Medicine

PATIENT PHOTOGRAPHIC CONSENT FORM

To: Baylor College of Medicine

I hereby consent to be photographed and allow the use of my portrait, picture, photograph, or any reproduction of same by you, or anyone you may authorize in writing, for the purpose of advancing scientific or scholastic news, in published professional journals, presentations at scientific meetings, patient information & viewing, as well as for media purposes. In addition, for confidentiality reasons, I will not be identified by name.

Please check and initial one of the two choices given below:

☐___Using adequate facial coverage ☐ ___Allow full facial exposure

____
Print Name

____
Signature

____
Date

If the person photographed is under the age of 18, please sign below:

____
Print Patient Name

____
Print Parent/Guardian Name

____
Signature of Parent/Guardian

Center *for* Aesthetic Surgery
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Patient Consent

Based on the current information stored in the EMPI, no patient consent is required. One of the future enhancements to be added is Payer information. Implementation of Payer information will be put in place 3rd Quarter of 2001. To add Payer information and to address upcoming HIPAA regulations, an EMPI patient consent form will be required.

ENTERPRISE MASTER PERSON INDEX (EMPI)
AUTHORIZATION FOR RELEASE OF INFORMATION

To improve our scheduling and registration service, Methodist Health Care System, Baylor College of Medicine, Texas Children 's Hospital, Saint Lukes Hospital, and their participating organizations have developed a centralized database that allows us to share your demographic (i.e. name, address, etc.) and insurance eligibility information among our institutions. We believe this sharing of information will reduce the time you spend registering at any of our facility, but we need your approval to do it.

Patient Name: ________________________________

Persons/Organizations providing information:
____

Purpose of the use or disclosure: Patient demographic information and insurance eligibility information will be entered into our database, which is called the Enterprise Master Person Index. 1-lospitals and other health care providers participating in the EMPI can access this index and save you time whenever you visit or schedule a visit with these organizations. We will not receive any compensation in exchange for using or disclosing the information you give us.

Terms of authorization: This authorization is voluntary. You are not required to give it, and your health care and the payment for your health care will not be affected if you do not sign this form. This
authorization will expire when the providing organization is no longer participating in the EMPI. You may revoke this authorization at any time by notifying the providing organization in writing, but his will not affect on any actions it took before it received the revocation. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under federal privacy regulations.

Consent to Release Information: I hereby authorize the use and disclosure of my demographic and insurance eligibility information, as described on the back of this form, among the hospitals and other health care providers participating in the EMPI.

____ ____________________________
Signature of patient or patient's representative Date

____ ____________________________
Printed name of patient's representative Relationship

Acknowledgment of Receipt of Privacy Notice

By signing this form, you are agreeing that you have received a copy of the Baylor College of Medicine Privacy Notice, which describes how we use and disclose your health information. You have the right to refuse to sign this Acknowledgment, in which case we must document our good faith effort to obtain your acknowledgment and the reason why it was not obtained.

Receipt of Privacy Notice acknowledged by:

______________________________ ____________ ______________________________
Signature Date Print name

Relationship to patient:
☐ Self ☐ Other: ____

Patient, spouse, legal representative, or beneficiary (Patient's spouse may authorize disclosure of patient's health information only when the health information is for the sole purpose of processing an application for health insurance, for enrollment in a health care service plan or an employee benefit plan, and where patient is to be an enrolled spouse or dependent under the policy or plan).

Statement of Financial Responsibility/Assignment of Benefits
Baylor College of Medicine

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of Baylor College of Medicine or BaylorMedCare. I assign and authorize payments to Baylor College of Medicine or BaylorMedCare. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law.

____

Signature of Patient or Guardian   Date

____

Printed Name of Patient or Guardian   Relationship to Patient

A duplicate or faxed copy of this form is considered the same as the original document.