

Craig Staebel M.D. P.A.
Plastic and Reconstructive Surgery

Name: _____ Age: _____ Date: _____

REASON FOR CONSULTATION : _____
Due to an injury? Y N On the job injury? Y N Auto Accident? Y N Date of injury/accident: _____

PAST MEDICAL HISTORY: (Have you ever had any of the following medical conditions?)

High blood pressure	Y N	Stomach ulcer or gastritis	Y N
Heart attack or congestive heart failure	Y N	Hepatitis or other liver disorder	Y N
Heart murmur or heart valve disorder	Y N	Kidney disease or failure	Y N
Asthma, bronchitis or COPD	Y N	History of blood clots in the veins of your legs	Y N
Stroke or paralysis	Y N	Anemia or any other blood disorder	Y N
Diabetes or thyroid disorder	Y N	Transfusion of blood or blood products	Y N
Autoimmune disease	Y N	Glaucoma or other eye disorder	Y N
Arthritis or degenerative joint disease	Y N	Seizure disorder	Y N
Cancer (What type? _____)	Y N	History of any psychiatric disorder	Y N

Any other medical problems (Be specific): _____

PAST SURGICAL HISTORY: (List all previous operations by date and any associated problems with the surgery or anesthetic)

<i>Surgery</i>	<i>Date</i>	<i>Problems with surgery or anesthetic</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS: (Prescriptions, over-the-counter and herbal)

<i>Medication</i>	<i>Dose</i>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES (Reaction to any medication, drug or anesthetic)

<i>Medication</i>	<i>Reaction</i>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY:

Marital status: S M D W Number of children: _____ Children at home: _____ Hobbies: _____
Do you use tobacco? Never In the past Occasionally Regularly Amount/day: _____ Number of years: _____
Do you drink alcohol? Never In the past Occasionally Regularly Amount/day: _____ Number of years: _____
Recreational Drugs? Never Occasionally Regularly _____

FAMILY HISTORY: (Any history of the following conditions in a blood relative? Which family members?)

High blood pressure	Y N	_____	Stroke	Y N	_____
Diabetes	Y N	_____	Bleed Disorder	Y N	_____
Cancer (type)	Y N	_____	Blood Clots/DVT	Y N	_____
Heart Disease	Y N	_____			

REVIEW OF SYSTEMS: (Have you recently experienced or do you currently have any of the following symptoms?)

Recent weight loss or easy fatigability	Y N	Pain or burning when you urinate	Y N
Fever, chills or night sweats	Y N	Pain in your extremities or major joints	Y N
Change in vision or temporary loss of vision	Y N	Slow wound healing or excessive scarring	Y N
Excessive tearing or excessively dry eyes	Y N	Change in size or color of a mole or other growth	Y N
Irregular heart rate or palpitations	Y N	New lumps or discomfort in your breast	Y N
Tightness, pressure or pain in your chest	Y N	Dizziness, light-headedness or faintness	Y N
Swelling of your feet or ankles	Y N	Weakness in any extremity	Y N
A recent cold, flu or pneumonia	Y N	Any unusual stress in your life at this time	Y N
Wheezing or shortness of breath	Y N	Any chance that you may be pregnant	Y N
Heartburn or reflux	Y N	Excessive or prolonged bleeding when cut	Y N
Frequent loose stools or constipation	Y N	Any known deficiency of your immune system	Y N
Blood in your stool or urine	Y N	Allergy or reaction to Latex	Y N

FOR OFFICE USE ONLY Ht ___ ' ___ " Wt _____ BP ___/___ P _____ R _____
Reviewer's Init: _____

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PERSONAL DATA:

Full name: _____ Name you like to be called: _____
Date of birth: _____ Age: _____ Sex: _____ Social Security Number: _____
Address: _____ City: _____ State: _____ Zip: _____
Home phone: _____ Work phone: _____ Cell phone: _____
E-mail address: _____
Marital Status: S M D W Spouse's Name: _____

EMPLOYER INFORMATION:

Employer: _____ Occupation: _____
Employer's address: _____ Phone Number: _____

RESPONSIBLE PARTY:

Name: _____ Relation to patient: _____
Address: _____ City: _____ State: _____ Zip: _____
Home phone: _____ Work phone: _____ Cell phone: _____

INSURANCE INFORMATION:

Name of primary carrier: _____ Phone number: _____
Address: _____ City: _____ State: _____ Zip: _____
Policy Number: _____ Group number: _____
Name of insured: _____ Relation to patient: _____
SS# of insured (if different) _____ Drivers license of insured _____
Name of secondary carrier: _____ Phone number: _____
Address: _____ City: _____ State: _____ Zip: _____
Policy number: _____ Group number: _____
Name of insured: _____ Relation to patient: _____

EMERGENCY CONTACT:

Name: _____ Relation to patient: _____
Address: _____ City: _____ State: _____ Zip: _____
Home phone: _____ Work phone: _____ Cell phone: _____

HOW DID YOU HEAR ABOUT US?

Physician referral: _____ Patient referral: _____
Website ___ LookingYourBest.com ___ Phonebook ___ Online Phonebook ___ Other: _____

Primary Care Physician _____

Is this visit due to any type of accident? No Yes: Date of Accident _____

Type of Accident Auto: State? _____ Work Related Other: _____

All Patients — Signature on File

I request that payment of authorized benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services. **I understand that I am financially responsible for all fees and charges not paid by my insurance company** and that they are due and payable within 30 days of service unless other arrangements have been made with the office, I further understand that should Craig Staebel M.D. P.A. have to refer my account for outside collections that I am responsible for all fees incurred by the agency or attorney/legal fees.

Beneficiary Signature _____ Date: _____

Medicare Patients Only - Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in Item 9 of the HCFA1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Craig Staebel M.D. P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Craig Staebel M.D. P.A. I understand that diagnosis or treatment of me by Dr. Craig Staebel may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Craig Staebel M.D. is not required to agree to the restrictions that I may request. However, if Craig Staebel M.D. PA agrees to a restriction that I request, the restriction is binding on Craig Staebel M.D., P.A. and Dr. Craig Staebel.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Craig Staebel or Craig Staebel M.D., PA has taken action in reliance on this consent.

I understand that photographs may be taken of me during the course of my treatment and are part of the medical record. These photos will not be shared or used in advertisement without my additional consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Craig Staebel M.D., P.A.'s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Craig Staebel M.D., P.A. This Notice of Privacy Practices also describes my rights and the Craig Staebel M.D., P.A.'s duties with respect to my protected health information.

Craig Staebel M.D., P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Craig Staebel M.D., P.A.'s website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority