

PLASTIC SURGERY ASSOCIATES OF NORTHERN VIRGINIA, LTD.

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www.plasurg.com

Patient Registration Form

Name: _____ Today's Date _____

Address: _____

City _____ State _____ Zip Code _____

Employer: _____

Name

Address

Phone

Appointment Confirmation Phone Number: _____ (H): _____

(C): _____ (W): _____

Date of Birth: ____/____/____ Age: ____ Sex: M F Marital Status: S M D W Sep

Height: ____ Weight: ____ Who referred you to our office? _____

Where should statements of your account be sent if different from above?

Name Address Apt # City State Zip

In case of Emergency, who should be notified? _____ Phone _____

Primary Care Physician _____ Phone _____

INSURANCE INFORMATION

Do you require a REFERRAL for this visit? _____

Primary Insurance Name _____ **Secondary** Insurance Name _____

Ins. Address _____ Ins. Address _____

Name of Insured _____ Name of Insured _____

Insured's ID# _____ Insured's ID# _____

Insured's Date of Birth: _____ Insured's Date of Birth: _____

Group # _____ Group# _____

Relationship of patient to the Insured _____ Relationship of patient to the Insured _____

Do we have your permission to:

Leave a message on your answering machine at home? YES NO

Leave a message at your place of employment? YES NO

Discuss your medical condition with any member of your household? YES NO

If yes, whom: _____ Relationship _____ Password: _____

Signature of patient or legal guardian

Date

Please present insurance cards and photo ID to the receptionist so copies may be made.

-OVER-

What brings you to our office? Please be as specific as possible _____
 How long have you had this condition? _____
 Have you had any previous treatment for this condition? _____
 If YES, how and when was this treated? _____

Review of systems:

Do you have or have you had any of the following? (Please check yes or no.)

	Yes	No		Yes	No
AIDS or HIV positive			Hepatitis		
Anemia			High blood pressure		
Arthritis			Irregular heart beat		
Asthma			Kidney problems		
Back problems			Migraine headaches		
Blood clots in legs			Nervous breakdown		
Blood disorders			Nose/throat problems		
Bleeding problems			Pneumonia		
Breathing problems			Psychiatric condition		
Cancer			Rheumatic fever		
Chest pains			Seizures		
Colitis			Shortness of breath		
Diabetes			Skin cancer		
Ear/Eye problems			Stomach problems		
Epilepsy			Stroke		
Heart problems			Thyroid problems		
Heart murmur			Tuberculosis		
Heart palpitations			Transfusion		

Past, Family and/or Social History:

Current medical conditions: _____

List any hospitalizations and/or previous surgery, including dates: _____

Are you allergic to or have you ever had a reaction to any medication or drug; local anesthetic; or general anesthetic? _____

Are you now or have you ever taken any medications regularly (aspirin, birth control pills, vitamins, etc.)?

Currently taking: _____

Previously taken: _____

Do you currently smoke: Yes No If yes, how many packs per day? _____ How many years? _____

Have you ever smoked? Yes No If yes, how many packs per day? _____ How many years? _____

Do you drink alcohol? Yes No If yes, how much? _____ How often? _____

Do you have any relatives who have had breast cancer? Yes No If yes, who? _____

Have you ever had a mammogram? Yes No If yes, when was your last one? _____

Have you had exposure to any of the following?

Radiation Yes No

Excessive sun Yes No

Do you have a problem with excessive scarring or keloid formation after being cut? Yes No

Is your general health good? Yes No

Have you ever had psychiatric problems, or been under the care of a psychiatrist, psychologist or mental health counselor? Yes No

Marketing Authorization

According to the Federal Government we must ask for your permission to send to you via email or regular mail information regarding our practice such as products we sell, promotions we have or any services the practice offers. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

This authorization is effective until revoked in writing.

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying PSANV in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by PSANV in reliance on this authorization before PSANV receives my request for revocation or modification. I must sign my written request and send it to:

Karen Kennedy
Plastic Surgery Associates of Northern Virginia, Ltd.
8180 Greensboro Drive #1015
McLean, VA 22102

I DO _____ I DO NOT _____

Authorize Plastic Surgery Associates of Northern Virginia, Ltd. ("PSANV") to use and disclose my individually identifiable Protected Health Information ("PHI") to mail to me any information regarding the products, services, or promotions that the practice offers.

Patient Signature

Date

Email Address

- If not signed by the patient, please indicate relationship:
- _____ Parent, guardian or caregiver of a minor patient.
 - _____ Guardian or conservator of an incompetent patient.
 - _____ Beneficiary or personal representative of a deceased patient.
 - _____ Other _____