PLASTIC & RECONSTRUCTIVE SURGERY

NAME: ________________________________ DOB: _______________ DATE: ___________________

PRIMARY CARE PHYSICAN: _________________________________ REFERRING PHYSICAN: _______________________

REASON FOR VISIT TODAY: ______________________________________ E-MAIL: _____________________________

PHARMACY: _____________________________________ PHARMACY TELEPHONE #: __________________________

MEDICATIONS (Include nonprescription drugs, Vitamins, and Herbal drugs) Do you take ASPIRIN? YES or NO

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

HEIGHT ______ ft ______ inches WEIGHT _________ lbs ALLERGIES _________________________________
____
____

Marital Status : S M D W

DO YOU SMOKE? Y N IF YES, HOW MUCH? ____ packs Have you ever smoked: Y N
Alcohol use? Y N IF YES, HOW MUCH? ____________________

General Medical History (Circle any that apply)

Alcoholism	Allergies/Hayfever	Anemia	Anxiety
Asthma	Atrial Fibrillation	Blood Transfusions	CAD
Cancer	Cardiac Pacer	Cardiovascular Disease	CHF
Cirrhosis	Colitis	COPD	CRF
Crohn's Disease	CVA	Depression	DM Type 1
DM Type 2	Epilepsy	Fracture	Gastric Ulcer
Gastrointestinal Disease	Glaucoma	Heart Murmur	Hepatitis
High Cholesterol	Hyperlipidemia	Hypertension	Hyperthyroidism
Hypothyroidism	Joint Pain	Kidney Infections	Kidney Stone
Migraine	Multiple Sclerosis	Obesity	Old MI
Osteoarthritis	Osteoporosis	Pneumonia	Progressive Neuro. Diso
Pulmonary Disease	Rheumatic Fever	Rheumatoid Arthritis	STD
Terminal Illness	Thyroid Disease	TIA	Tuberculosis

OTHER MEDICAL HISTORY:

____
____

Surgical Procedures (Circle any that apply)

No prior surgical history	Appendectomy	Breast Lumpectomy	Cataract Surgery
Colectomy	Cone Biopsy	D&C	Endometrial Ablation
Gallbladder	Heart Surgery	Hemorrhoids	Hernia
Hysterectomy	Laparoscopy	Mastectomy	Myomectomy
Oophorectomy	Tonsil/Adenoidectomy	Tubal Ligation	

OTHER SUGERICAL PROCEDURES:

____
____

Preventative Care

Chest X-Ray _______________ date Eye Exam _______________ date
EKG _______________ date Labs Drawn _______________ date
Mammogram _______________ date Radiology Group ______________________________

PATIENT SIGNATURE: ______________________________________ DATE: ______________________

Beth Collins, M.D.

PLASTIC & RECONSTRUCTIVE SURGERY

CONSENT FOR PHOTOGRAPHS, DIGITAL IMAGING, AND Video

In connection with, and in consideration of medical services for which I have been receiving, or am about to receive from Beth A. Collins, M.D.; I hereby consent that clinical photographs, digital imaging, or video may be taken of me, or parts of my body, under the following conditions:

The photographs/digital imaging/video shall be taken only with the consent of my physician and under such conditions and at such times as may be approved by him/her.

The photographs/digital imaging/video shall be taken by my physician or by a photographer approved by my physician.

____________ The photographs/digital imaging/video shall be used for medical record purposes and shall remain the property of Beth A. Collins, M.D.

____________ The photographs/digital imaging/video shall be used for website, advertising, meetings, or educational purposes.

____________ The photographs/digital imaging/video shall be used for advertising in print and television.

Series of Pictures Pertaining To: ____

____ _________________________

Signature of Patient/Personal Representative Date

____ _________________________

Witnessed By Date

2614 Boston Post Road, Guilford Gatehouse West, Suite 16C, Guilford, CT 06437 (203) 689-5295

Beth Collins, M.D.

PLASTIC & RECONSTRUCTIVE SURGERY

PATIENT NAME: ____ SS#: ________________________ (Last)
(First) (Initial)

ADDRESS: ____

CITY: ____________________________________ STATE: ___________ ZIP: ________________

AGE: ______ DATE OF BIRTH: ___________________ SEX: M/F MARITAL STATUS S/M/D/W

HOME PHONE (_______)___________________ WORK PHONE (_______) _____________________

CELL PHONE (_______) ___________________ E-MAIL ___________________________________

MAY WE CONTACT YOU ABOUT UPCOMING OR MISSED APPOINTMENTS? YES NO

PLEASE GIVE PREFERRED CONTACT INFORMATION: ____________________________________

EMERGENCY CONTACT: __________________________ RELATIONSHIP: ___________________

HOME PHONE (_______) ___________________ WORK PHONE (_______) ____________________

HEALTH INSURANCE INFORMATION:

Cosmetic patients may give name of insurance company only. Please have your insurance card available for us to photocopy and fill in the information below if you expect insurance to cover non-cosmetic surgery.

PRIMARY INSURANCE: ________________________ INS. CO. PHONE: (_______)____________________

MAILING ADDRESS FOR CLAIMS: ____

POLICY – OR- ID #: _________________________ POLICY HOLDERS NAME: _______________________

POLICY HOLDERS DOB: __________________ GROUP NUMBER: ________________________________

SECONDARY INSURANCE:

PRIMARY INSURANCE: ________________________ INS. CO. PHONE: (_______)____________________

MAILING ADDRESS FOR CLAIMS: ____

POLICY – OR- ID #: _________________________ POLICY HOLDERS NAME: _______________________

POLICY HOLDERS DOB: __________________ GROUP NUMBER: ________________________________

I hereby authorize Beth A. Collins, M.D. to submit a claim to my insurance carrier or to Medicare for all the covered services which have been rendered and direct my insurance carrier to issue payment to Beth A. Collin, M.D., P.C.. I further authorize the release of any medical information needed by the above to intermediaries to pay an insurance claim. My signature is good for a lifetime of treatment. Beth A. Collins, M.D., P.C. will not bill your health insurance for cosmetic surgery.

I understand and agree that I am responsible for any amount not covered by my insurance carrier.

SIGNATURE: ____ DATE: ________________________

Beth Collins, M.D.

PLASTIC & RECONSTRUCTIVE SURGERY

ARRIVAL AND CANCELLATION POLICY

Please arrive 15 minutes prior to your scheduled service. New clients must reserve their appointment with a credit card payment. Dr. Collins' initial consultation fee is $150.00. There is a $100.00 payment taken for all laser appointments with our laser technician at the time of booking that will go toward treatment. There is a $50.00 payment taken for all Med Spa appointments at the time of booking that will go toward treatment. If an appointment is cancelled within 24 hours, the consultation/booking fee will be refunded. Otherwise it is non-refundable.

I have read and understand the arrival and cancellation policy stated above.

Patient name: ______________________________________

Signature: __________________________________

Date: ______________

Beth Collins, M.D.

PLASTIC & RECONSTRUCTIVE SURGERY

Notice of Privacy Practices Acknowledgement

And

Patient Consent

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ____

Signature: ____

Relationship to Patient: __________________________________

Date: ___________________________________

Beth Collins, M.D.

PLASTIC & RECONSTRUCTIVE SURGERY

Dear Patient: Our goal is to respond to all of our patient's needs and to provide the highest quality care. In order to provide the information and services you desire on the health and appearance of your skin, we invite you to complete the following questionnaire. *Please check all that are of concern to you:*

[ ]	Lines around my eyes	[ ]	Crease nose to corner of mouth
[ ]	Lines between my eyes (angry look)	[ ]	Frown on corner of mouth
[ ]	Lines on forehead	[ ]	Brown spots
[ ]	Lines under eyes	[ ]	Red, blotchy skin
[ ]	Puffy eyes	[ ]	Excess skin above eyes
[ ]	Thin lips	[ ]	Thin face, no cheeks
[ ]	Dry skin	[ ]	Dimpled chin
[ ]	Oily skin	[ ]	Gummy smile
[ ]	Looking tired	[ ]	Sunk in eyes
[ ]	Broken capillaries	[ ]	Unwanted fat

Please check all that are of interest to you:

[ ]	Botox	[ ]	Skin care analysis
[ ]	Dermal Fillers	[ ]	Skin care products
[ ]	Kybella/More defined jaw line	[ ]	Skin texture
[ ]	Skin rejuvenation	[ ]	Facial and eye treatments
[ ]	Microdermabrasion	[ ]	Hair removal
[ ]	Acne treatment	[ ]	Removing leg veins
[ ]	Chemical peels	[ ]	Spider vein treatments
[ ]	Laser resurfacing	[ ]	Removing facial veins
[ ]	Lengthen lashes	[ ]	Spider vein treatments
[ ]	Other:________________________	[ ]	Surgical Procedures

How did you hear about us?

[ ] My physician (full name) ____________________________________

[ ] Ad (specify advertisement) ___________________________________

[ ] A friend or family member (name) ______________________________

[ ] Other ____________________________