(Confidential)

Patient Name ______________________ Date ______________

Birthdate ______________ Age ____________ Height ____________ Weight ____________

Reason for visit? ____

Whom may we thank for your referral? ______________________ Newspaper ____________ Other ____________

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period __________

Date of last Pap Smear __________

Have you had a mammogram? __________

Are you pregnant? __________

Number of children __________

Conditions

Check (✓) symptoms you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Medications

List medications you are currently taking.

____

____

____

____

Pharmacy Name ______________________ Phone ____________

Allergies

____

____

____

____

____

Health History

Family History

Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following:

✓	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates ______

Serious Illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which substances you use and describe how much you use.

✓	Substance	
	Caffeine	
	Tobacco	
	Drugs	
	Other	

Occupational

Check (✓) if your work exposes you to the following:

✓		✓	
	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation ______

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

______ Signature ______ Date

______ Reviewed By ______ Date

CHARLES G. POLSEN, M.D.
Plastic & Reconstructive Surgery

2622 Marina Bay Drive
League City, TX 77573
Telephone (281) 538-6600

REGISTRATION

Date: ____________________ Home Phone: (________) __________-____________ Cell: (________) __________-_____________

Patient: ____

Last Name First Name Middle Initial

Responsible Party (if a minor):____

Street Address: ____

City: ___________________________________ **State:** ________________ **Zip:** ______________

Email: ____________________________ Sex: ☐ M ☐ F Patient's Age: __________ Birth Date:______________

Status: ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for ____ years

Responsible Party Employer: ____

Business/School Address: ____

City:_________________________________ State:________________ Zip:______________

Occupation: ___________________________ Business/School Phone: (________) __________-___________

Who is responsible for this account? ___________________________ Relationship to Patient: ________________

***Patient SS #** ___________-__________-___________

Primary Insurance ______________________________ Plan Type ____________________

Policy Holder's Name ____________________________________ Policy Holder's DOB _________________

ID #_________________________ Group # _______________ Policy Holder's SS# _______________________

***In case of emergency, who should be notified?** Name:__________________________ Relationship:_____________

Phone: (_______) _________-____________

How did you learn of our practice? ____

Legal Assignment of Benefits and Designation of Authorized Representative

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am legally responsible for all actual total charges expressly authorized by me regardless of any applicable insurance or benef payments. I hereby authorize the above name provider(s) to release all medical information necessary to process my claims under HIPPA. I hereby authorize any pla administrator of fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider(s), to full extent permissible under the laws, including but not limited to, ERISA §502(a)(1)(A), §502(a)(1)(B), §502(a)(2), and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, statutory penalties, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medica; expenses legally insured as a result of medical services I received form the above named provider(s), and to the fill extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursements and any applicable remedies, including, but not are limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, choose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses, Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignments is to be considered as valid as the original. I have read and fully understand this agreement.

X____ ________________________
Signature of Beneficiary, Guardian or Personal Representative Date

X____ ________________________
Please Print Name of Beneficiary, Guardian or Personal Representative Relationship to Beneficiary

South Shore Plastic Surgery
Charles G. Polsen, M.D.

Board Certified
Plastic & Reconstructive Surgery
Diplomat American Board of Plastic Surgery
2622 Marina Bay Drive
League City, TX 77573
281-538-6600
Fax 281-535-2800

Authorization for Disclosure of Information

I authorize Dr. Charles Polsen to disclose complete information concerning his medical findings and treatment of the undersigned, from the initial office visit until the date of the conclusion of such treatment, to those individuals who, in Dr. Charles Polsen's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

Patient's
Signature:____ Date:________________

Witness:____

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Authorization For Use and Disclosure of Protected Health Information (PHI)

1. Uses and Disclosure of (PHI)

Your Protected Health Information (PHI) will be used by the Practice or disclosed to others for the purpose of treatment, payment, and healthcare operations, law enforcement or public health safety. The practice will require your consent or authorization to disclose PHI for other purposes.

2. Notice of Privacy

The Practice will give you a Notice of Privacy about policies for disclosure of PHI. You should review this document carefully. It recognizes your rights as a patient and details how your PHI will be disclosed. You must sign this notice and receive a signed copy of the notice.

3. Request for Restrictions to Use or Disclose PHI

You may request a written restriction on the disclosure of your PHI. The practice will agree to your request. It will not use or disclose the restricted PHI. Violation of this agreement will be a violation of the federal privacy standard.

4. Revocation of Authorization or Consent

You may revoke this consent by written statement at any time. The Practice will honor your request. Any use or disclosure of your PHI prior to this date will not be affected by the revocation.

5. Reservation of Right to Change Privacy Practice

The Practice reserves the right to modify the privacy practices outlined in the notice.

6. Signature of Patient or Patient Representative

I have reviewed the authorization form and give my permission to the Practice to use or disclose my health information in accordance with the above authorization and the guidelines of HIPPA regulation.

____

Name of Patient

____

Signature of Patient Date

____

Signature of Patient Representative Relationship