Bergman Folkers Plastic Reconstructive & Hand Surgery

Receipt of Notice of Privacy Practices

Acknowledgment of Receipt of Notice of Privacy Practices

I would like to request the following restrictions on the uses and disclosures of my protected health information. Please check the applicable line.

_____ I do not wish to be contacted about reminder appointments by phone.

_____ I do not wish to be contacted about reminder appointments by mail.

_____ I do not wish to be contacted about future open houses or seminars regarding cosmetic procedures and/or products.

If the above restricted information is needed to provide me with emergency treatment, or cancellation of an appointment due to an emergency on part of Bergman Folkers Plastic Reconstructive & Hand Surgery, you may suspend the above agreement.

_____

Name of Patient or Personal Representative (Printed)

_____

Signature of Patient or Personal Representative

_____

Date

****

My Signature on this form indicates that I have received a Notice of Privacy Practices. If you have any questions, please contact our Privacy Officer at 515-222-1111.

_____

Name of Patient or Person Representative (Printed)

_____

Signature of Patient or Personal Representative

_____

Date

Bergman Folkers Plastic Reconstructive & Hand Surgery

Patient Information Sheet

Patient: ***(All fields must be completed to file insurance)***

Legal Name_____

First Middle Last

Male ☐ Female ☐ Age_____ Date of Birth_____

Address_____City_____State____Zip_____

Home Phone# (_____) _____Cell Phone # (_____) _____

Social Security Number: _____ (Needed to file your insurance)

Email: _____

Student ☐ Yes ☐ No If yes ☐ Full time ☐ Part time

Marital Status: Please circle Married Single Divorced Widow/Widower

Employer's Name_____

Employer's Address (Complete) _____

Employer's Phone (_____) _____

Spouse:

Legal Name_____

First Middle Last

Date of Birth_____

Social Security Number: _____

Employer's Name_____

Employer's Address (Complete) _____

Employer's Phone (_____) _____

Person Responsible for payment (if other than patient):

Legal Name_____

First Middle Last

Relationship to patient_____

Social Security Number: _____

Date of Birth: _____

Address_____ Home Phone # (_____) _____

Employer's Name_____

Employer's Address (Complete) _____

Employer's Phone (_____) _____

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All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance.

Insurance Coverage

A COPY OF THE INSURANCE CARD MUST BE PRESENTED AT TIME OF VISIT

(Need all lines completed in order to file insurance)

Primary Insurance:

Insurance Name_____

Person Carrying Ins._____

Date of Birth_____

Relationship to patient_____

ID#: _____

Group#:_____

Effective Date:_____

Employer insured through:_____

Secondary Insurance:

Insurance Name_____

Person Carrying Ins._____

Date of Birth_____

Relationship to patient_____

ID#:_____

Group#:_____

Effective Date:_____

Employer insured through:_____

Referring Physician Information:

Doctor Name_____ Address_____

Phone Number_____

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In case of an emergency, name of person NOT living with patient we can contact:

Name_____Phone#_____

Relationship to patient:_____

****

Patient Signature and/or Parent or Guardian: _____

Today's Date: _____

Bergman Folkers Plastic Reconstructive & Hand Surgery

Patient Medical History

Name:_____Date:_____

How were you referred to us today?

☐ By another physician (name)_____

☐ Phone Book ☐ Newspaper ☐ Radio ☐ TV ☐ Friend ☐ Other_____

Allergies:_____

Are you allergic or sensitive to latex, balloons, rubber, etc? ☐ Yes ☐ No Last tetanus?_____

Family physician:_____

Why are we seeing you today?_____

_____

Were you seen in the emergency room? ☐ Yes ☐ No If yes When ?_____

Were X-rays or any other test taken for this injury? ☐Yes ☐ No

If yes,explain:_____

Do you take medications for any reason (prescription and/pr over the counter)? ☐ Yes ☐ No

If so please list them:_____

_____

_____

Are you a current smoker? ☐ Yes ☐ No If yes amount per day:_____

Do you have a history of smoking? ☐Yes ☐ No If yes amount per day, how long and your quit date?

_____

Do you drink alcohol? ☐ Yes ☐ No Amount per day?_____ For how long?_____

Do you or have you ever used narcotics? ☐ Yes ☐ No If yes, please explain:_____

Have you ever had any of the conditions listed below? If yes, please give details.

Anemia . . . . . ☐ Yes ☐ No

Asthma/Hayfever/Allergies ☐ Yes ☐ No

Blurred/ Double Vision . . . ☐ Yes ☐ No

Cardiac Problems . . . . . ☐ Yes ☐ No

Chest Pain . . . . . ☐ Yes ☐ No

Chronic Cough . . . . . ☐ Yes ☐ No

Colitis/ Bowel Disease . . . . ☐ Yes ☐ No

Diabetes . . . . . ☐ Yes ☐ No

Ear/Nose/Throat Problems . ☐ Yes ☐ No

Gallbladder Disease . . . . . ☐ Yes ☐ No

Heart Murmur . . . . . ☐ Yes ☐ No

Hepatitis/Yellow Jaundice . . ☐ Yes ☐ No

HIV/AIDS . . . . . ☐ Yes ☐ No

Hypertension. . . . . ☐ Yes ☐ No

Kidney Disorder . . . . . ☐ Yes ☐ No

Pneumonia . . . . . ☐ Yes ☐ No

Polio/Meningitis . . . . . ☐ Yes ☐ No

Psychiatric Disorder . . . . . ☐ Yes ☐ No

Rheumatic Fever . . . . . ☐ Yes ☐ No

Seizure Disorder . . . . . ☐ Yes ☐ No

Tuberculosis . . . . . ☐ Yes ☐ No

Unconscious/Fainting Spells ☐ Yes ☐ No_____

Have you ever been pregnant? ☐ Yes ☐ No

If yes, number of: vaginal deliveries_____ c- sections_____ miscarriages_____ abortions_____

Have you ever had surgery before? ☐ Yes ☐ No

If yes, Please list names of all surgeries:_____

_____

_____

Have you ever had a general anesthetic? ☐ Yes ☐ No

If yes, any adverse reactions?_____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, date:_____

FAMILY HISTORY:

Cancer . . . . . ☐ Yes ☐ No_____

Diabetes . . . . . ☐ Yes ☐ No_____

Epilepsy . . . . . ☐ Yes ☐ No_____

Heart Disease . . . . . ☐ Yes ☐ No_____

High Blood Pressure . . ☐ Yes ☐ No_____

Is there any other significant history that we should be aware of? ☐ Yes ☐ No If yes, explain:_____

_____

To the best of my knowledge, the medical information supplied is accurate and complete.

Signature of Patient or Parent/Legal Guardian:_____ Date:_____

This Section to be completed by physician or nurse

B/P Height: Weight:

HEENT:

Cardiovascular:

Respiratory:

Gastrointestinal:

Urogenital:

Extremities:

Neurological:

Physician's Signature:_____ Date:_____

Nurse's Signature:_____ Date:_____