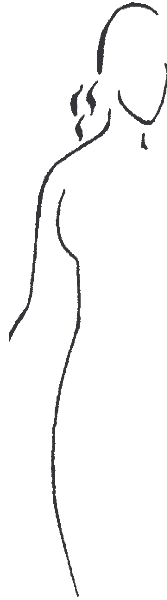
Malcolm Rude, M.D., P.A.

Plastic & Reconstructive Surgery

To: Malcolm Rude M.D. P.A.	From:
Fax 979-776-2655	Date:
Phone Number: 979-776-8825	Total Number of pages including cover page: 7
RE: Patient Registration forms	



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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:_______

Daytime phone: _____________________ Evening phone: _______________Cell phone: ______________

Pager number: ___________________________ E-mail address: _______________________________________

EMPLOYER INFORMATION:

Employer: ____ Occupation: ___________________________

Employer's address: ___________________________________Phone number: _________________________

RESPONSIBLE PARTY:

Name: ____Relation to patient: ____________________________

Address: _____________________________________City: ______________ State: ______ Zip: ______

Daytime phone: ________________ Evening phone: ________________ Cell phone: _________

INSURANCE INFORMATION:

Primary Insurance Company: ___________________________________ Phone number: ____________________

Address: _____________________________________City: ______________ State: ______ Zip: ______

Policy number: _________________________________ Group number: ______________________________

Name of policyholder: _________________________________ Date of birth: ________________________________

Relation to Patient: ____________________________________ Employer: ____________________________________

Social Security # of policy holder_______________________Does this insurance require a referral? Yes or No

Secondary Insurance Company: ___________________________________ Phone number: __________________

Address: _____________________________________City: _____________ State: ______ Zip: ______

Policy number: _______________________________________ Group number: _______________________

Name of policyholder: ___________________________________ Date of Birth: ______________________________

Relation to Patient: ___________________________________ Employer: ___________________________________

Date of accident or occurrence of condition: ____________________ Type of accident: Auto Work Related Other

EMERGENCY CONTACT:

Name: ____Relation to patient: ____________________________

Address: _____________________________________City: ______________ State: ______ Zip: ______

Daytime phone: ___________________ Evening phone: _______________Cell phone: ______________

WOULD YOU LIKE US TO SHARE YOUR MEDICAL INFORMATION? ___ WITH WHOM___________

REFERRAL INFORMATION:

Physician referral: ____________________ Patient referral: _______________Other: _________

Primary Care Physician______________________

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Insurance Authorization

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 45 days of service unless other arrangements have been made with the office. I further understand that should Malcolm Rude 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 HCFA-1500 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 Malcolm Rude 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 Malcolm Rude M.D., P.A. I understand that diagnosis or treatment of me by Dr. Malcolm Rude 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. Malcolm Rude M.D., P.A. is not required to agree to the restrictions that I may request. However, if Malcolm Rude M.D., P.A. agrees to a restriction that I request, the restriction is binding on Malcolm Rude M.D., P.A. and Dr. Malcolm Rude.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Malcolm Rude or Malcolm Rude M.D., P.A. has taken action in reliance on this 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 Malcolm Rude M.D., P.A.'s Notice of Privacy Practices prior to signing this document. The Malcolm Rude M.D., P.A.'s Notice of Privacy Practices has been provided to me. 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 Malcolm Rude M.D., P.A. This Notice of Privacy Practices also describes my rights and the Malcolm Rude M.D., P.A.'s duties with respect to my protected health information.

Malcolm Rude 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 Malcolm Rude 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 ____________________

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REASON FOR VISIT TODAY: ____

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	Autoimmune disease	Y N
Stroke or paralysis	Y N	Anemia or any other blood disorder	Y N
Diabetes	Y N	Transfusion of blood or blood products	Y N
Thyroid disorder	Y N	History of any psychiatric disorder	Y N
Arthritis or degenerative joint disease	Y N	Glaucoma or other eye disorder	Y N
History of blood clots in the veins of your legs	Y N	Seizure disorder	Y N
Any other medical problems (Be specific): ______________________		Cancer (What type? __________________)	Y N

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

SURGERY	*DATE*	*PROBLEMS WITH SURGERY OR ANESTHETIC*

MEDICATIONS: (**All** prescription and over-the-counter medications)

MEDICATION	*DOSE / FREQUENCY*

ALLERGIES: (Reaction to any drug or anesthetic)

MEDICATION	*REACTION*

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: ___________

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

High blood pressure	Y N ______________________	Heart disease	Y N ______________________
Diabetes	Y N ______________________	Stroke	Y N ______________________
Cancer (type)	Y N ______________________	Bleeding disorder	Y N ______________________

REVIEW OF SYSTEMS: (Have you recently experienced or do you currently experience 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 scaring	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_____

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PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I consent to the taking of photographs by Dr. Rude or his designee of me or parts of my body in connection with the plastic surgery procedures(s) to be performed by Dr. Rude.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Rude.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because all parties acting under Dr. Rude's license and authority are not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA and may be redisclosed by parties acting under Dr. Rude's license and authority.

I release and discharge Dr. Rude, and all parties acting under his license and authority from all rights that I may have in the photographs and from any claim that I may have relating to the photographs.

As a patient you will have access to your photos as they will be a part of your medical record.

This is NOT releasing your photos to be used in advertisement. This form allows Dr. Rude to have the photos as a part of the medical record. There is a separate form to release your photos to be used or published in any print, visual or electronic media, including advertisements.

Patient X___________________________ Date ___________________________

WITNESS/PHYSICIAN: ______________________________

I have read the above Authorization and Release. I am the parent, guardian or conservator of ___________________________, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

Parent/Guardian ___________________________ *Date* ___________________________

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Breast Information

Please answer the below questions.

What is your current bra size? _____

What is your current Height _____feet _____inches?

What is your current weight _______lbs?

How many children have you had? _____ How many were breast fed? _____

Have your breasts been changing in size recently?	YES	NO
Have you had radiation of your breasts?	YES	NO
Diagnosed with breast cancer?	YES	NO
Has your maternal grandmother had breast cancer?	YES	NO
Has your mother had breast cancer	YES	NO

Number of maternal aunts? ____Number with breast cancer? _____

Number of sisters? _____ Number with breast cancer? _____

Diagnosed with fibrocystic disease?	YES	NO

What was the date of your last mammogram? Date ________ (month) ______ (year)

Was it normal?	YES	NO

Have you ever had any of the below symptoms:

Breast pain	YES	NO
Breast infection	YES	NO
Nipple drainage	YES	NO

Have you ever had any of the following procedures?

Cyst aspiration,	YES	NO
Breast biopsy	YES	NO
Breast surgery,	YES	NO

Patient Signature: ____________________Today’s Date: ____________Reviewed by: _____

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Desired result: nat’l/augmented
Desired size A / B C / D /DD

R | L

SSN
IMCN
Width
Cup: A B C D DD /A B C D DD
Size: R < = > L

Chest Shape: nl / keel / pectus
Musculature: nl / hyper
Intermamm: nl / wide / narrow
Breast vector: ant / lat / med
Tubular: none / mild / mod / severe
Striae: none / mild / mod / severe
Envelope: tight / mod / loose
Creases: even / RT LT lower
Ptosis: 0 1 2 3 4 pseudoptosis

Masses Y N
Adenopathy Y N

Submusc / Subfascial / Subgland
Silicone Saline
Pt liked RT:______LT:______ sizers
Implant: RT:_______LT:________
Sizer______