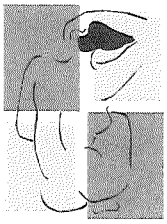

Taylor Theunissen, MD

AESTHETIC PLASTIC SURGERY

4309 Bluebonnet Blvd.,
Baton Rouge, LA 70809
225.218.6108
www.drtplasticsurgery.com

Patient Information

Please Print Clearly

Date_____

Patient's Full Name _____

Gender: Male_____ Female_____ Birthdate_____ Age _____

Address_____ City_____

State_____ Zip _____ Email_____

Home Phone_____ Cell Phone_____

Any restrictions for contacting you? No YES Please list restrictions:_____

_____

Single_____ Married_____ Other_____ If under 18, parent's name_____

Patient's Employer _____ Occupation_____

Work Phone_____ Is it OK to call you at work? Yes NO

How did you hear about Dr. Theunissen? (Please circle all that apply)

TV Radio Yellow Pages Magazine Brochure Website Google

Friend/Relative_____ Doctor_____

Other _____

If you were referred by a specific person, may we thank them? Yes No

Emergency Contact _____ Phone Number_____

Relationship to Patient _____ Phone Number_____

Cosmetic procedures are not covered by insurance. Payment for cosmetic surgery is due three weeks in advance of your surgery date. If cosmetic fees are not paid in full at that time, your surgery will be cancelled. Dr. Theunissen spends a considerable amount of time in describing the elective nature of these procedures. As you are fully informed of all the limitations and risks of the procedure, we do not provide refunds for services already provided.

Date_____ Signature_____
Patient, Parent or Legal Guardian

POS® Reorder # 1309881

Confidential Record

Information contained here will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your doctor in decisions regarding your care.

Name:_____
Last First Middle

Age_____Ht._____Wt._____Sex_____ Marital Status: S M W D or Separated

Date of Last Physical Examination_____ Physician's Name_____

Family or Referring Physician_____ Address & Phone No._____

DO YOU HAVE OR HAVE YOU HAD: (CIRCLE)

Stroke	YES	NO	Bladder Infection	YES	NO
Cancer	YES	NO	Asthma	YES	NO
Tuberculosis	YES	NO	Heart Attack	YES	NO
Leukemia	YES	NO	Stomach Ulcers	YES	NO
Bronchitis	YES	NO	Kidney Disease	YES	NO
Epilepsy	YES	NO	Tonsillitis	YES	NO
Pneumonia	YES	NO	Keloids / Thick Scars	YES	NO
Diabetes	YES	NO	Rheumatic Heart	YES	NO
Arthritis	YES	NO	Bleeding Tendency	YES	NO
Depression	YES	NO	High Blood Pressure	YES	NO
Hepatitis / Jaundice	YES	NO	Congenital Heart Disease	YES	NO
Migraine	YES	NO	Nervous Breakdown	YES	NO
Hay Fever	YES	NO	Dizziness / Fainting	YES	NO
Colitis	YES	NO	AIDS	YES	NO
Goiter	YES	NO	Sickle Cell Disease	YES	NO
Mitral Valve Prolapse	YES	NO	Latex Allergies	YES	NO
Sleep Apnea with or without CPAP machine	YES	NO	Deep Venous Thrombosis	YES	NO

What procedure are you interested in?_____

Do you wear dentures? YES NO

Do you smoke? YES NO How much?_____ How many years?_____

Do you drink alcohol or beer regularly? YES NO How much?_____

Date of Last Chest X-ray_____ Date of Last EKG _____

ARE YOU PRESENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS? (CIRCLE)

Aspirin, Bufferin, Anacin	YES	NO	Medicine for Arthritis	YES	NO
Blood pressure pills	YES	NO	Tranquilizers	YES	NO
Cortisone	YES	NO	Weight reducing pills	YES	NO
Digitalis	YES	NO	Blood thinning pills	YES	NO
Hormones	YES	NO	Dilantin	YES	NO
Insulin or diabetic pills	YES	NO	Shots	YES	NO
Iron or poor blood meds	YES	NO	Water pills	YES	NO
Laxatives	YES	NO	Antibiotics	YES	NO
Sleeping pills	YES	NO	Barbiturates	YES	NO
Thyroid medicine	YES	NO	Birth control pills	YES	NO
Headache pills	YES	NO	Phenobarbital	YES	NO

Have you ever taken or are you presently taking diet pills? YES NO When? _____

Other drugs not listed: Name _____ dosage _____

Write in the names and dates of any operations which you have had: _____

_____

Name any drugs or foods to which you are allergic: _____

_____

Serious injuries or accidents: _____

_____

Do you have eye problems?	YES	NO
("dry eye syndrome", glaucoma, detached retina, allergic reactions, etc.)		
Do you wear glasses or contact lenses?	YES	NO
Have you ever had a blood transfusion?	YES	NO
Do you frequently have bleeding gums?	YES	NO
Have you ever bled excessively from a tooth extraction?	YES	NO
Do you bleed excessively from a laceration?	YES	NO
Do you have nose bleeds?	YES	NO
How often? _____		
Do you take aspirin regularly?	YES	NO
How often? _____	YES	NO

(Yes, stop taking aspirin until two weeks after your surgery)

WOMEN ONLY

Are you still having regular monthly menstrual periods?	YES	NO
Are you now on or have you ever taken the birth control pill? When? _____	YES	NO
Have you ever had bleeding between your periods? When? _____	YES	NO
Do you have very heavy bleeding with your periods? When? _____	YES	NO

Date of last Pap Smear Test _____

Any complications of pregnancy? _____

Date of last menstrual period _____ Could you be pregnant now? _____

Do you have any family history of breast cancer? _____

Date of last mammogram _____

NOTE: We recommend regular breast and pelvic exams by your regular physician for all adults.

Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff of Dr. Gruenwald and Dr. Theunissen, to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices for Dr. Gruenwald and Dr. Theunissen.

Name and relationship of the person you wish to allow access – for example, your spouse, child, sibling, neighbor, caretaker, clergy, or close friend:

Name of Person or Entity **Relationship**

_____

_____

_____

_____

This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me.

I understand that information used or disclosed pursuant to this authorization may be disclosed by Dr. Gruenwald and Dr. Theunissen, and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information to obtain payment from my health insurance company.

_____ _____

Signature of Patient or Personal Representative Print Name of Patient or Personal Representative

_____ _____

Description of Personal Representative's Authority Date

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Signed: _____ Date: _____

Print:
Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship and describe authority to act:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only:

Signed form received by: _____

Acknowledgement refused:

Good Faith Efforts to obtain Acknowledgement:

_____

_____

Reasons acknowledgement was not obtained:

_____

Policy Holder Information

MR# _____

Patient Name: _____ Date of Birth: _____ Sex: M F

Insured: _____ Date of Birth: _____ Sex: M F
Last First Middle

Mailing Address: _____
Address City State Zip

Home Phone: (___) _____ Cell Phone: (___) _____

Work Phone: (___) _____ Relationship to Patient: _____

Employer: _____

Insurance Information

Primary

Insurance Company: _____

Insurance Address: _____

State: _____ Zip: _____

Policy I.D. #: _____

Group #: _____

Phone: _____

Secondary

Insurance Company: _____

Insurance Address: _____

State: _____ Zip: _____

Policy I.D. #: _____

Group #: _____

Phone: _____

ASSIGNMENT OF BENEFITS

I, the undersigned, do hereby authorize the assignment of all medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, Workers Compensation insurance, and any liability settlement payments to Taylor Theunissen, M.D.

_____ Initial I, the undersigned, do acknowledge that if my insurance contract requires a co-payment, there will be a co-payment due. I hereby authorize Taylor Theunissen, M.D. to release all information necessary to secure the payment for said benefits. I understand that the benefits represented to me are not a guarantee of payment by my insurance company. I acknowledge I am ultimately responsible for all charges incurred and any balance remaining after insurance has paid.

_____ Initial If your injury is work related, we will file all charges with your employer's insurance carrier. We will accept reimbursement from the carrier as payment in full for the treatment you receive.
If your employer does not accept responsibility for your injury, you will be asked to pay for the charges you incur at our office.

_____ Initial If your injury resulted in a litigation process, we must receive a letter of representation from the attorney who is representing your claim. Payment in full is due three weeks prior to surgery.

_____ Initial If you are a Medicare patient, we will file claims for your services directly with Medicare and any supplemental insurance that you may have. If you do not have supplemental insurance you will be responsible for paying any unmet deductible and the 20% co-insurance.

WAIVER OF LIABILITY

_____ Initial I have been informed by the office staff and fully understand that the services performed, or the supplies received, may not be covered by my insurance carrier or the secondary insurance carrier, regardless of whom files for payment. I realize that anything not covered by my insurance company will be my full responsibility.

_____ _____
Signature Date
Patient/Parent or Legal Guardian

_____
Patient's Name (Print)