KLEINERT KUTZ
HAND & AESTHETIC PLASTIC SURGERY

Kleinert Kutz Plastics & Aesthetic
Patient Registration Form

KLEINERT KUTZ
HAND & AESTHETIC PLASTIC SURGERY

Patient Name:_____DOB:_____SS#:[redacted]

Address:_____Apt #:_____City:_____

State:_____Zip:_____Home: (_____)_____Cell: (_____)_____

Email address:_____

Sex: Male □ Female □ Marital Status: Married □ Divorced □ Single □ Widow □ Student (Y/N):_____if yes – Full time □ Part time □

Employer:_____Employer Address:_____

Employer, City, State & Zip:_____Work: (_____)_____

Referring MD, Address & Phone:_____

Emergency Contact:_____Phone: (_____)_____Relation:_____

Spouse's Name – if Insurance Policy Holder

Fill out only if your spouse is the policy holder on your insurance plan.

Spouse's Name:_____DOB:_____SS#[redacted]

Cell: (_____)_____Work: (_____)_____Employer:_____

Employer's Address, City, State & Zip:_____

Guarantor Information – if patient is a Minor

If insurance is through someone other than mother or father, please put their info at the bottom of this section.

Mother's Name:_____DOB:_____SS#:[redacted]

Address (if different than above):_____Cell: (_____)_____

Employer & Address:_____Work: (_____)_____

Father's Name:_____DOB:_____SS#:[redacted]

Address (if different than above):_____ Cell: (_____)_____

Employer & Address:_____ Work: (_____)_____

Other Responsible Party (**If not Parents above**):_____DOB:_____

Relation:_____ SS#:[redacted]Phone: (_____)_____

Employer & Full Address:_____

Payment Information

We must obtain copies of ALL insurance cards if filing with your insurance policy.

Primary (**check one**): Personal pay □ or Personal Insurance □ – If using personal insurance, please fill out below.

Name of Insurance Co.:_____ ID #:_____

Name of Policy Holder:_____Relation to Patient:_____

Secondary Insurance:_____ID#:_____

Name of Policy Holder:_____Relation to Patient:_____

Office Use Only

Hospital/Physician: _____Date: _____Xray #: _____

KLEINERT KUTZ
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Consent to Treatment, Authorization to Release Information and Payment Information

KLEINERT KUTZ
HAND & AESTHETIC PLASTIC SURGERY

I hereby consent to the rendering of care, including diagnostic procedure and treatment, as the attending physician or physicians under their supervision consider appropriate and necessary. I understand that I will be informed of the risks of any proposed procedure and treatment and I should decline treatment unless such risks are explained to my satisfaction. I also consent to the taking of photographs in the course of medical treatment.

I hereby authorize the release of information regarding my condition and treatment to any referring or consulting healthcare personnel, and health, accident, auto or worker's compensation carrier, any agent, attorney or other representative purporting to act of my behalf, at any facility at which I may be treated, examined or evaluated.

I hereby authorize my current insurance carrier to pay Kleinert Kutz out any benefits due on this claim. I understand that I am financially responsible to the doctor for any charges not covered. I understand that Kleinert Kutz **may** or **may not** be a participating provider with my insurance carrier and it's **my responsibility** to verify this status with my insurance. I agree that any additional request for information form my insurance regarding coverage, coordination of benefits, or related questions will be answered by me in a timely manner, or the balance due will become my responsibility.

If I have insurance Kleinert Kutz will help me receive maximum benefits. All payments are due at time of service, such as co-payments, deductibles and/or any other fees deemed my responsibility. In the event this matter is referred for collections, I agree to pay all court costs, collection fee, and attorney fees associated with the collection of this account.

THIS IS A LEGALLY BINDING DOCUMENT – READ BEFORE SIGNING

I understand and agree that all of the provisions of this CONSENT TO TREATMENT, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT INFORMATION shall remain in full force and effect until revoked by me IN WRITING.

Patient Name (**please print**):_____

Signature(**patient or Legal Guardian**):_**X**_____

If patient is a minor, they are _____ years of age. Date:_____

ACCUTANE RELEASE

I acknowledge that I have not taken oral Pharmaceutical medication Accutane (or its equivalent) within the past twelve months. I understand the potential risks involved with Accutane therapy and the problems that could occur when employed in conjunction with skin care programs, treatments and surgery.

Patient (**please print**):_____

Signature: (**patient or Legal Guardian**):_____

Date:_____

Kleinert, Kutz and Associates **Medical History**

Plastic, Cosmetic and Aesthetic Service

Name_____Age_____Date_____

Occupation_____Weight_____Height_____

Reason for this visit_____ Referred by_____

Have you seen other physicians regarding this issue? Yes_____ No_____ If so, how many?_____

Have you received unsatisfactory medical care? _____

Primary Care Physician_____ Phone # _(_____)_____

Address_____ City, State, Zip_____

Have you ever had surgery or been hospitalized? Yes_____ No_____ If yes, please fill in the below:

OPERATION	ANESTHESIA (local or general)	DATE	ANY PROBLEMS?

Have you or anyone in your family had a problem, complication or reaction to anesthesia? If so, describe. _____

_____

Smoking: □ Never □ Current smoker □ History of smoking -- If ever, number of years?_____ number of packs a day?_____

I drink **alcohol**: □ Never □ Rarely □ Monthly □ Weekly □ Daily

Do you use **illicit drugs**? Yes_____ No_____ If so, what kind(s)?_____How Often?_____

Do you suffer or been diagnosed from any of the following ? (Circle all that apply)							
Cold sores/Herpes		**Easy bruising/Anemia Prolonged bleeding/clotting problems, pulmonary embolis, swelling and blood clots of legs**		**Chest pain, Heart Disease, Heart surgery, stint placement, pacemaker, arrhythmia, angioplasty**		**Arthritis, osteo or rheumatoid**	
Headaches		**Thyroid**		**Cancer**		**Diabetes, type 1 or 2**	
Dizziness/Fainting		**Dependency/Alcoholism**		**High blood pressure**		**Birth control or estrogen medicine**	
Lumps/masses of what area of the body		**Epilepsy/Seizures, seizure medicine**		**Kidney disease or bladder problems**		**HIV+/Aids**	
Vision issues/glaucoma, dryness of eyes		**Changes in skin/moles, history of skin cancer, family history of skin cancer**		**Stroke**		**Varicose Veins**	
Eating Disorder		**Facial paralysis**		**Mental Illness/Psychiatric Care, depression**		**Bone disease**	
Sleep apnea, cpap or bipap machine		**Gout**		**Chronic pain, treatment under MD supervision**		**Hernia**	
Chronic nausea, diarrhea, acid reflux, bowel, hiatal hernia, and or pancreas problems		**Artificial joint replacement, list what area:**		**Bronchitis, pneumonia, lung disease, breathing problems, asthma., emphysema**		**Jaudice, ulcers, hepatitis, liver disease**	
Currently being treated for chronic wound?		**Currently on antiobotics for upper respiratory, urinary tract or tooth infection?**		**Disabled**		**History of VRE, MRSA**	

Any other diagnosed problems not listed on previous sheet:

Does anyone in your family have a history of disease?_____

Are you currently taking cold medicines?_____
Are you currently taking lasix or dilantin? _____

Are you pregnant? _____ Are you trying to become pregnant? _____ Date of last menstrual period?_____

Do you regularly take aspirin, ibuprofen, Aleve, Motrin, Excedrin, Fish Oil, Vitamin E, multivitamins, blood thinners or Advil? _____ If so, why?_____

History of taking these blood thinning **medicines**: Aspirin, Plavix, Warfarin, Coumadin, Xerelto, Effient, Pradaxa?

Have you ever had a blood transfusion?_____ Why?_____ Any reaction?_____

DRUG Allergies: Yes____, No_____,

Please list all other allergies and reactions below:

LATEX ALLERGY: Yes_____ No_____

Current Medications & Dosages (Include hormones, birth control pill, antibiotics, vitamins and herbs):

Drug:	Dosage:	How often:

This information is true and complete to the best of my knowledge.

Signed: **x**_____

Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of the Notice Of Privacy Practices**,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

If you would like to have a copy of the Notice of Privacy Practices for your own records, please request one at the registration desk.

SIGNED: _X_____DATE: _____

If not signed by the patient, please indicate relationship to patient (e.g., parent, legal custodian)

Relationship: _____

Witnessed by**: _____**

IF THE PATIENT OR REPRESENTATIVE REFUSES OR IS UNABLE TO SIGN, INDICATE YOUR ATTEMPT TO OBTAIN A SIGNATURE BELOW.

[ ] Patient refused to sign this acknowledgement

[ ] Patient is unable to sign due to injury

DATE: _____ TIME: _____

EMPLOYEE: _____

WITNESS: _____

This acknowledgement applies to the following business entities:

Kleinert, Kutz and Associates PLLC
Christine M. Kleinert Institute for Hand and Microsurgery, Inc.
Kleinert Kutz Surgery Center
in affiliation with Floyd Memorial Hospital and Health Services