MIDWEST
Breast & Aesthetic Surgery

New Patient Form

Name:_____ Date of Birth:_____/_____/_____

Address:_____ Zip Code:_____

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

Email Address:_____

Primary Doctor (& city of practice):_____

Referral Doctor (& city of practice):_____

Oncologist (& city of practice):_____

Medical Problems (please check all that apply):

- ○ Diabetes
- ○ Heart Disease
- ○ Asthma or COPD
- ○ High blood pressure
- ○ Bleeding disorder/blood clots
- ○ Sleep Apnea
- ○ Pacemaker/AICD

Drug Allergies (please list):_____

Are you allergic to any of the following?

- ○ Latex
- ○ Iodine
- ○ Metal
- ○ Penicillin
- ○ Adhesives/Tape

Current Medications (list all, including vitamins):_____

_____

Surgery History:

- ○ Tummy Tuck
- ○ C Section
- ○ Hysterectomy
- ○ Appendix
- ○ Gall Bladder
- ○ Mastectomy
- ○ Other_____
  _____

Do you smoke or use any form of tobacco/nicotine? YES NO

Patient Signature:_____ Date:_____/_____/_____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the named health care provider to release the information or records specified to Midwest Breast & Aesthetic Surgery upon request in person or by mail to the address specified at the time of the request.

Provider (name & address):

_____

_____

_____

Patient:_____

SSN:_____

DOB:_____

RECORDS AUTHORIZED TO BE RELEASED:

- Surgery & operative notes
- Lab reports
- Radiological images
- Other (Specify):_____

Dates: _____

Extent or nature of records to be released (example, specific hospitalization or visit):_____

_____

This information will be used for the purpose of:

- Investigating an allegation of abuse
- Providing advocacy services
- Verifying my eligibility for services offered by Midwest Breast & Aesthetic Surgery
- Legal representation
- Other activities at the request of the individual

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the health care provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that Midwest Breast & Aesthetic Surgery may redisclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original.

Patient/Representative:_____ Date:_____/_____/_____

Printed Name:_____Relationship to Patient:_____

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Insurance Information

Name of Policy Holder:_____Employer:_____

Relationship to Policy Holder:_____

Policy Holder's Date of Birth:_____ Policy Holder's SSN:_____

Member ID:_____ Group #:_____