PATIENT REGISTRATION

Richard Y. Ha, MD

Referred By:			Date:
How did you hear about us?			
PATIENT INFORMATION			
Full Name:			
SS#	DOB	Age	Male Female
Preferred Phone	Cell	Work Phone	
E mail address	DL#	Pharmacy Phone	
Mailing address			
City, State, Zip			
Employment (if minor, responsible parties)			
Employed By			
Position		May we call your work Yes No	
Address			
Marital Status Married Single Separated Divorced Widowed			
Spouse's name		SS #	
Spouses employer		Phone	
Address		State, Zip	
IN CASE OF EMERGENCY			
Name	Relationship	Phone	
Name	Relationship	Phone	

_____

I understand that I am financially responsible for all charges. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, money orders and most major credit cards.

Signature:_____Date:_____

INSURANCE INFORMATION

Patient name		**Male Female**
DOB	Age	SS #

Primary insurance		
Insurance Company		
Insured		Relation to Patient
DOB	Male Female	SS#
Insurance claims address		
Insurance Precertification #		
Policy #	Group #	

Secondary insurance		
Insurance company		
Insured	Relation to patient	
DOB	Male Female	SS#
Insurance claims address		
Insurance Precertification #		
Policy #	Group #	

Assignment of Benefits
I hereby assign all medical and / or surgical benefits for private insurance (Not to include Medicare, unless specific arrangements have been made) to: Dallas Plastic Surgery Institute. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure the payment.
Signature Date

HEALTH HISTORY FORM

Name				Date	
Address					
DOB	Age	Height	Weight	Phone #	
Reason for visit today?					

Past current History (check all applicable)

Lung Disease_____ High Blood Pressure_____ Asthma_____ Keloids_____

Liver Disease_____ Mitral Valve Prolapse_____ Hepatitis_____ Fever Blisters_____

Heart Disease_____ Diabetes_____ Seizures_____ Sleep Apnea_____

Abnormal or Excessive bleeding_____ Neck problems_____ Use CPAP/BPAP

Taken Accutane with in past year_____ Aspirin or blood thinners_____

Other Major Illnesses:

Medication Name	Reason for taking	Frequency/Dose

Do you take ANY Diet Pills, Natural Herbs or Health Food Supplements? If Yes, what_____

_____

_____

Allergies and Reactions to Medication?_____

_____

_____

Previous Surgeries:_____

_____

_____

Have you or anyone in your family had complications from anesthesia? If yes, please explain:_____

_____

_____

Has anyone in your family had breast cancer the age of 50? If yes explain:_____

_____

Have you been on ANY steroids in the last year? If yes, please explain:_____

_____

Do you take aspirin on a regular basis? Yes No

Do you have excessive bleeding or Bruising? Yes No

Do you use any Tobacco Products? Yes No

Are you pregnant: Yes No

Do you have any teeth that are: _____ Loose

____ Fragile ____ Capped _____ False

Signature Date