FENNER PLASTIC SURGERY & MEDICAL SPA

PATIENT INFORMATION

Please Print

Today's Date: _____

Title: Dr Mr Mrs Ms First name: _____Last name: _____Middle initial: ____

Address: _____

City: _____ State: _____ Zip: _____

SS#_____ Age: ____ Date of Birth: _____ Gender: M F Marital Status: M S W D

Drivers License number (if a minor, please use guarantor) Issuing State: _____ Number: _____

Phone (H): _____ Phone (W): _____ ext. _____ Phone (C): _____

Email: _____ Preferred method of contact: Home Work Cell Email

Education: _____ Occupation:_____ Race:_____

PHYSICIANS INFORMATION	
Referring Physician	**Phone #**
Address	
Primary Physician	**Phone #**
Address	
Referring Patient	**Phone #**

If you were not referred, how did you hear about us?

- ☐ Friend
- ☐ Magazine
- ☐ Past Patient
- ☐ Television Commercial
- ☐ Our Website
- ☐ Newspaper
- ☐ Search Engine
- ☐ Yellow Pages
- ☐ Medical Literature

AUTHORIZATIONS

I authorize Fenner Plastic Surgery to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Fenner Plastic Surgery determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and *if applicable* to process the insurance claim for services rendered at Fenner Plastic Surgery.

Signature: _____

Date: _____

512 GREEN BAY ROAD
KENILWORTH, ILLINOIS 60043
847.716.2400 *phone*
847.716.2401 *fax*
WWW.FENNERPLASTICSURGERY.COM

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

H I P A A

I, _____have been informed that a copy of our office's Notice of Privacy Practices is available upon request. A copy of this Notice will be furnished to me upon my request.

_____ _____
Signature of Patient Date

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

It is our policy to not release confidential and/or unauthorized information except appointment confirmation by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself please complete the following:

I authorize the doctor's office to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them, in writing, whenever this information changes.

Home telephone	yes____ no ____	Voice mail	yes____ no____
Answering machine	yes____ no____	Cell phone/voice mail	yes____ no____
Work phone	yes____ no____	Pager	yes____ no____
May we fax medical records for referrals?	yes____ no____		

EMERGENCY CONTACT INFORMATION:

Emergency Contact:_____ Relationship to patient:_____
Phone (cell):_____ Phone (work)_____ext._____ Phone(home):_____
Preferred method of contact: ☐ Home ☐ Work ☐ Cell ☐ Email

Please list names of people we can discuss your medical or skin care with:
Spouse Name _____ yes____ no____
Parent Name _____ yes____ no____
Other Name _____ yes____ no____
Please give name and relationship such as boyfriend, sister, etc.

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CONSENT TO PHOTOGRAPHS

I, _____ (print full name) understand that photographs will be taken periodically throughout my treatments. These photographs will be used to monitor progress and other factors. I understand that failure to consent to these photos will give Fenner Plastic Surgery the right to decline my treatment.

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

I grant Dr. Geoffrey Fenner the right to use photographs of me, in the following areas: (initial all/any for use)

_____All
_____Website for Consumers
_____Newsletter to be sent to patients
_____Practice brochures
_____Public relations material
_____Seminars
_____Patient before and after photo information sheets

If in the judgment of my physician, medical research, education or science will benefit by their use, the photographs and information relating to my case maybe published and republished in professional journals and medical books, or used for any other purpose which he may deem proper in the interest of medical education, knowledge, or research. I understand that in any such publication or use I shall not be identified by name.

I understand that such photographs may become the property of medical organizations or publications including but not limited to the ASPS, PRS, ASAPS, ASIF, Facial Plastic Surgery, Annals of Plastic Surgery or compatible journals and such organizations.

I understand that I may refuse to authorize the release of any photo documentation and that my refusal to consent to the release of photo documentation will prevent the disclosure of such information, but will not affect the health care services is presently receive, or will receive.
☐ Check Box to Refuse to release photograph documentation.

I understand that by signing below Fenner Plastic Surgery need not approach me again for authorization on these photos.

_____ _____
(Patient Full Name – Please Print) (Patient Signature)

_____ _____
(Witness Full Name – Please Print) (Witness Signature)

_____ _____
(Date) (Date)

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GUARANTOR INFORMATION

(The guarantor is the responsible party for insurance payments and charges.)

☐ **CHECK HERE, IF SAME AS PATIENT INFORMATION**	
GUARANTOR NAME	**SSN**
RELATIONSHIP TO PATIENT	OCCUPATION
HOME ADDRESS	
CITY, STATE, ZIP	
BUSINESS NAME	EMPLOYER
BUSINESS ADDRESS	
CITY, STATE, ZIP	
HOME PHONE	BUSINESS PHONE

PRIMARY INSURANCE INFORMATION		
INSURANCE COMPANY NAME		
POLICY HOLDER'S NAME		
INSURANCE ID NUMBER	GROUP NUMBER	
POLICY HOLDER'S DOB	SSN	RELATIONSHIP TO PATIENT
ADDRESS		CITY/STATE/ZIP
HOME PHONE	BUSINESS PHONE	

SECONDARY INSURANCE INFORMATION	
☐ **CHECK HERE, IF NONE**	
INSURANCE COMPANY NAME	
POLICY HOLDER'S NAME	RELATIONSHIP TO PATIENT
INSURANCE ID NUMBER	GROUP NUMBER

Please note we will need to make a copy of your driver's license or state issued photo ID for your record.

AUTHORIZATIONS

Payments: With your signature on this form, you confirm you understand and agree that you are ultimately responsible for the services ever rendered by the Dr. Geoffrey Fenner. This includes all fees, co-payments and deductibles due at the time of the services as well as charges ever associated with surgeries, hospitalizations, scheduled office visits and/or procedures.

I authorize payment of medical benefits for treatment and/or surgery to Fenner Plastic Surgery.

If you self paid a surgery, procedure or office visit, regardless if it is for reconstructive or cosmetic services provided, you agree not to bill later your insurance company for Dr. Geoffrey Fenner provider fees.

If my account is turned over to an attorney or collections agent to obtain payment, then I shall be responsible for the attorney's fee, court costs, and any other costs incurred by the collection agency. A copy of my signature shall have the same force and affect as the original.

Signature:_____
Date:_____

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Assignment of Benefits

An assignment of benefits is an arrangement by which a patient authorizes their health insurance benefit payments be made directly to the provider.

I, _____,
Patient's Printed Name

hereby authorize Fenner Plastic Surgery, LTD, further referred to as the "Practice", to submit claims to my health insurance company on my behalf. I request that payments made by my health insurance company be sent directly to the Practice.

I certify that I have valid insurance coverage and will keep the Practice up to date regarding any changes to my insurance policy in a timely manner. Insurance denials for timely filing due to non-responsiveness will become my fiscal responsibility.

All office visits for insurance covered diagnoses will be billed to my insurance and is subject to my plan benefits, i.e. deductible/copay.

I understand it is my responsibility to contact my insurance company regarding network status and benefits. The billing office is available as a resource to assist me in this process.

Any and all procedures performed in the office or the hospital are considered surgical by insurance definitions and are subject to surgical insurance benefits. The subsequent post-op visits may be covered by insurance for up to 0, 10 or 90 days, depending on the procedure. Any visit after the time period dictated by insurance, will be subject to plan benefits, i.e. deductible/copay, unless otherwise stated by Geoffrey C. Fenner, MD.

Insurance fees are not collected up front. Billing statements are sent out monthly. First electronically, then via USPS. Due to the appeals process, I may receive my bill from the Practice up to 1 year after my appointment date. The Practice is willing to set up payment plans for balances and there are no interest charges on payments. If I am non-responsive to attempts to collect payments, my account may be forwarded to a collection agency. I understand that there is a $30.00 fee for returned checks.

Any further questions or concerns, should be directed to the Billing Office at 847.716.2416.

X_____
Patient's Signature

X_____
Patient's Printed Name

X_____
Date

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MEDICAL HISTORY

NAME	DOB	DATE

CHIEF COMPLAINT (Reason you came to the doctor)
BRIEF HISTORY OF PRESENT ILLNESS/CONDITION
LIST WHEN AND HOW YOUR CONDITION STARTED
ASSOCIATED SYMPTOMS

SOCIAL HISTORY

OCCUPATION	MARITAL STATUS
SMOKING ☐ No ☐ YES Pack per Day _____ How Long _____ Quit Date _____	
ALCOHOL USE ☐ NONE ☐ RARE ☐ OCCASIONALLY ☐ FREQUENT	HISTORY of ALCOHOL ABUSE: ☐ YES ☐ NO
RECREATIONAL DRUG USE ☐ DENIED ☐ MARIJUANA ☐ COCAINE ☐ HEROIN ☐ PAIN MEDS ☐ METH	

SURGICAL HISTORY (Past Surgeries with Dates)

BREAST	ABDOMEN	FACIAL
COSMETIC:	OTHER:	

Surgical Complications:

ANESTHESIA PROBLEMS

☐ YES ☐ NO Explain:_____

PAST MEDICAL HISTORY

NONE	☐ YES ☐ NO	HIV/ AIDS	☐ YES ☐ NO
BREAST CANCER	☐ YES ☐ NO	KIDNEY	☐ YES ☐ NO
BLEEDING TENDANCY	☐ YES ☐ NO	LIVER DISEASE	☐ YES ☐ NO
DIABETES	☐ YES ☐ NO	LUNG DISEASE	☐ YES ☐ NO
EYE PROBLEMS	☐ YES ☐ NO	MENTAL ILLNESS	☐ YES ☐ NO
HEART DISEASE/MI	☐ YES ☐ NO	NEUROLOGIC DISEASE	☐ YES ☐ NO
HEART MURMUR	☐ YES ☐ NO	OTHER CANCER	☐ YES ☐ NO
HIGH BLOOD PRESSURE	☐ YES ☐ NO	SKIN CANCER	☐ YES ☐ NO
HISTORY DVT/PE	☐ YES ☐ NO	THYROID DISEASE	☐ YES ☐ NO
SLEEP APNEA	☐ YES ☐ NO		

FAMILY HISTORY (indicate which Blood Relative)

SKIN CANCER	DIABETES	STROKE
BREAST CANCER	HEART DISEASE	ABNORMAL BLEEDING
OTHER CANCER	MALIGNANT HYPOTHERMIA	OTHER

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CURRENT MEDICATIONS

☐ See List Please list dosage and schedule ☐ None	
1.	4.
2.	5.
3.	6.

NON-PRESCRIPTION DRUGS

ASPIRIN: ☐ YES ☐ NO **IBUPROFEN: ☐ YES ☐ NO** **HOMEOPATHIC: ☐ YES ☐ NO** **SBE PROPHYLAXIS: ☐ YES ☐ NO**

Steroids in the last 12 months: ☐ Yes ☐ No
Do you take a Blood Thinner? ☐ Yes ☐ No Name:_____

Allergies to Medications:
☐ Penicillin ☐ Lidocaine ☐ Other:_____
☐ Latex ☐ Tape

Have you had recent weight gain? Yes Recent weight loss ____ lbs loss ____ lbs gain

Height: _____ Current Weight: _____

REVIEW OF SYSTEMS

Fever / Chills:	☐ Yes ☐ No	History of Transfusions:	☐ Yes ☐ No
Stomach Ulcer:	☐ Yes ☐ No	Difficulty Swallowing:	☐ Yes ☐ No
Night Sweats:	☐ Yes ☐ No	Allergies:	☐ Yes ☐ No
Reflux:	☐ Yes ☐ No	Speech Changes:	☐ Yes ☐ No
Vision Loss:	☐ Yes ☐ No	Enlarged Thyroid/Goiter:	☐ Yes ☐ No
Back/Neck Pain:	☐ Yes ☐ No	High Blood Pressure:	☐ Yes ☐ No
Double Vision:	☐ Yes ☐ No	Enlarged Gland/Node:	☐ Yes ☐ No
Nerve Pain/Paralysis:	☐ Yes ☐ No	Chest Pain or Tightness:	☐ Yes ☐ No
Dry Eye:	☐ Yes ☐ No	Frequent Sunburns:	☐ Yes ☐ No
Facial Weakness:	☐ Yes ☐ No	Asthma/Breathing Problems:	☐ Yes ☐ No
Nasal Obstruction:	☐ Yes ☐ No	History of Sleep Apnea:	☐ Yes ☐ No
Depression/Anxiety:	☐ Yes ☐ No	Scarring/ Keloids:	☐ Yes ☐ No
Difficulty Urinating:	☐ Yes ☐ No	Shortness of Breath:	☐ Yes ☐ No
Drug or Alcohol Dependency:	☐ Yes ☐ No	Renal Failure/Dialysis:	☐ Yes ☐ No
Sinus Problems:	☐ Yes ☐ No	Breast Mass/Lump:	☐ Yes ☐ No
History of Abnormal Bleeding:	☐ Yes ☐ No	Hepatitis/Jaundice:	☐ Yes ☐ No

FEMALE PATIENTS

Are you currently pregnant? ☐ Yes ☐ No

Do you take birth control pills? ☐ Yes ☐ No
Are you Planning Pregnancy? ☐ Yes ☐ No

Are you currently breast feeding? ☐ Yes ☐ No ☐ In the past
Have you had a c-section? ☐ Yes ☐ No If so, when? _____

When was your last mammogram? _____ ☐ 1 year ☐ 5 year

Patient / Parent's Guardian Signature _____ Date: _____

Reviewed with Patient By: _____ Date:_____

Addendum's: _____ Date: _____

Updated with Patient By: _____ Date:_____

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