Patient Registration

RICARDO A. MEADE, M.D. PA
9101 N. Central Expy. Ste. 600
Dallas, TX 75231

	Account No. (Office Use Only)
Referred By	Date
How did you hear about us?	
Would you like to be added to our mailing list? ☐ Yes ☐ No Thanks	

Patient

Full Name			
Social Security No.	D.O.B.	Age	☐ Male ☐ Female
Home Phone	Work Phone	Fax Phone	
Cell Phone	Preferred Phone	Pharmacy Phone	
Email Address		Drivers License No.	
Mailing Address			
City, State, Zip			

Employment (if minor, responsible parties)

Employed By	
Position	May we call you at work? ☐ Yes ☐ No
Address	

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name	Social Security No.
Spouse's Employer	Phone No.
Address	

In Case of Emergency

Name	Relationship	Phone No.
Name	Relationship	Phone No.

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 _____

Health History Form

Dr. _____

Name					Date
Address					
D.O.B.	Age	Height	Weight	Home Phone	Work Phone
Reason for visit today?					

Past/Current Hx (Check all applicable)

- ☐ Lung Disease
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Chest Pain
- ☐ Diabetes
- ☐ Asthma
- ☐ Hepatitis
- ☐ HIV
- ☐ Seizures
- ☐ Keloids
- ☐ MRSA
- ☐ Fever Blisters
- ☐ Dry Eyes
- ☐ Abnormal or Excessive Bleeding
- ☐ Taken Accutane with in Past Year
- ☐ Neck Problems
- ☐ Sleep Apnea
  - ☐ Use CPAP/BPAP

Other Major Illnesses:

Medications: 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 before the age of 50? If Yes, please explain: _____

_____

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

_____

Do you take asprin 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

Insurance Information

Account No. (Office Use Only)	
Patient Name	☐ Male ☐ Female

D.O.B.	Age	Social Security No.

Primary Insurance

Insurance Company		
Insured		Relation to Patient
D.O.B.	☐ Male ☐ Female	Social Security No.
Insurance Claims Address		
Pre-Certification Phone No.		
Policy No.		Group No.

Secondary Insurance

Insurance Company		
Insured		Relation to Patient
D.O.B.	☐ Male ☐ Female	Social Security No.
Insurance Claims Address		
Pre-Certification Phone No.		
Policy No.		Group No.

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	
Dr.	Date

NICOTINE HISTORY

Dr. Meade's goal is to achieve the very best possible result in wound healing.

Whether you are exposed to nicotine by secondhand, social smoking, nicotine patch/gum, regular smoking, tobacco chew, electronic cigarettes with nicotine; the same risk applies and it can affect wound healing.

Please describe your nicotine history:

_____ I have NEVER smoked in my life. (including, nicotine, gum, patch, cigars, cigarettes, etc.)

_____ I only smoke SOCIALLY _____ cigarettes/cigars per week.
My most recent exposure was on _____ (date).

_____ I smoked in the PAST: _____ cigarettes/per day for _____ years.
I stopped _____ (date).

_____ I am a CURRENT smoker: I smoke _____ cigarettes/per day for _____ years.

_____ I don't smoke, but I am exposed to secondhand smoke at: work/home/lifestyle.

Printed Name_____Date_____

Signature_____

DALLAS PLASTIC SURGERY INSTITUTE
RICARDO A. MEADE, M.D.
9101 N. CENTRAL EXPRESSWAY ,STE# 600
DALLAS, TX 75231

PHOTOGRAPH CONSENT FORM
CONSENTIMIENTO DE FOTOGRAFIAS

I understand that the photographic information will be used for patient education, but not limited to my medical records, such as distributing the images via print, visual and electronic media, specifically including the doctormeade.com website. I understand that **my identity will not be revealed by the pictures or by the descriptive texts accompanying them.** I hereby release, discharge and agree to hold harmless Dr. Ricardo Meade, M.D., P.A. and its affiliates and their respective representatives, employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my images and name and the reproduction thereof as stated above, including any claim for payment in connection with distribution of the images.

Yo entiendo que las fotografias seran usadas con fines de educación, para mi expediente medico, y autorizo la distribucion de las imágenes en medios visuales y electrónicos, especialmente para la pagina de doctormeade.com. Yo entiendo que **mi identidad no se dara a conocer por las imagenes o por el texto descriptivo acompanantes.** Yo libero, descargo y acepto mantener indemne al Dr. Ricardo A. Meade, M.D., P.A. y sus afiliados y sus respectivos representantes, empleados, y cualquier otra persona actuando bajo el permiso o autorización, de y contra cualquier reclamación de ningún tipo en conexion con el uso de mis imagenes y nombre y la reproduccion de la misma como se ha indicado anteriormente, incluyendo cualquier reclamacion de pago en conexion con la distribucion de las imagenes.

PERSON PHOTOGRAPHED/ PERSONA FOTOGRAFIADA

PRINT/ESCRIBA your name:_____

SIGN/FIRMA:_____DATE:_____

WITNESS/TESTIGO:_____ DATE:_____

DALLAS
PLASTIC SURGERY
INSTITUTE

RICARDO A. MEADE, M.D.
PLASTIC SURGERY

AMERICAN SOCIETY OF
PLASTIC SURGEONS

Patient Consent for Use of Email Communications

To better serve our patients, this office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at [insert your email address.] Please remember however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is 24 to 48 hours. The service provider may delay message delivery. **Should you require urgent or immediate attention, this medium is not appropriate.** When sending email, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name, patient ID number and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature. Communications relating to diagnosis and treatment will be filed in your medical record. This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to me, my staff and/or colleagues would have access to this information.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above email policy.

By signing below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

Patient signature_____ Date_____

Witness (optional)_____ Date_____

DALLAS PLASTIC SURGERY INSTITUTE
9101 N. CENTRAL EXPRESSWAY, SUITE 600 • DALLAS, TEXAS 75231
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The physicians of Dallas Plastic Surgery Institute have developed Dallas Day Surgery Center of North Texas, Pine Creek Medical Center, Forest Park Medical Center Frisco, and The Cloister to provide clean, safe caring environment for our patients. While the physicians are investors in the facilities, and may at times receive an investment distribution, the management directive is to provide the best quality of care at the most economical cost to patients.

Patient Signature Date

Patient Printed Name

Los doctores de Dallas Plastic Surgery Institute han desarrollado Dallas Day Surgery Center of North Texas, Pine Creek Medical Center, Forest Park Medical Center Frisco, y The Cloister para proporcionar un ambiente limpio, con cuidado seguro para nuestros pacientes. Mientras que los doctores son investores en estas instalaciones, y pueden recibir una distribucion de las inversiones, la directiva de gestion es de proporcionar la major calidad de atencion y al costo mas economico a nuestros pacientes.

Firma de Paciente Fecha

Nombre de paciente

DALLAS PLASTIC SURGERY INSTITUTE

Patient Consent and Acknowledgment of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Dallas Plastic Surgery Institute creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must agree to any restriction on the use and disclosure of my Protected Health Information that I request in writing, when I request in writing, agree to terminate any restrictions on the use and disclosure of my protected Health Information which have been previously agreed upon.

(PATIENT'S NAME PRINTED)	DATE
PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)	SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)
WITNESS (optional)	DATE

DALLAS PLASTIC SURGERY INSTITUTE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At Dallas Plastic Surgery Institute (hereafter referred to as "the Practice"), privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide service to you, to process your claims and to bring you health information that might be of interest to you.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us at the telephone numbers or addresses listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How - and why - information is shared

We limit who receives information and what type of information is shared.

- *Sharing information within the Practice.* We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.

- *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.

- *Other.* Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us-whether it's at our office, over the phone or through the Internet.