

# PLASTIC & RECONSTRUCTIVE SURGERY

DEBORAH PAN, MD      JAVIER J. DAVILA, MD

Date: \_\_\_\_\_  
Referral: WOM: \_\_\_\_\_ Advertising: \_\_\_\_\_ Dr: \_\_\_\_\_

Name: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Home phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Reason for referral: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Business phone: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Spouse's name: \_\_\_\_\_

If minor:      Mother's name: \_\_\_\_\_ Employer: \_\_\_\_\_  
                  Father's name: \_\_\_\_\_ Employer: \_\_\_\_\_  
                  Pediatrician: \_\_\_\_\_

Financial Guarantor of this Account: check here if self

Name: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Home phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Nearest contact: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Home phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Insurance Carrier:  
Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Insured's name: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance Carrier:  
Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Insured's name: \_\_\_\_\_ Group #: \_\_\_\_\_

Primary physician: \_\_\_\_\_ Office phone: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Fax #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

# MEDICAL HISTORY

Age: \_\_\_\_\_ Height: \_\_\_\_\_' \_\_\_\_\_" Weight: \_\_\_\_\_lbs

Please list all medical conditions:

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Have you had any previous surgery? If yes, please describe and outline dates of occurrence:

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Have you ever been hospitalized? If yes, please explain and outline dates of occurrence:

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Please list all medications you are currently taking (include vitamins, supplements, over the counter):

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## Do you have any of the following:

Congenital heart defect	Y	N	Do you smoke?	Y	N
Cardiovascular disease (heart attack, stroke)	Y	N	Do you drink?	Y	N
High blood pressure	Y	N	Are you pregnant?	Y	N
Diabetes	Y	N	Do you have a pacemaker?	Y	N
Blood diseases (AIDS, hemophilia, herpes)	Y	N	Do you have any joint replacements?	Y	N
Asthma	Y	N	Do you have any implanted devices?	Y	N
Seizures	Y	N			
Arthritis	Y	N			
Kidney problems	Y	N			
Psychiatric illness	Y	N			

## Drug Allergies:

Local anesthesia	Y	N	Narcotic medications (pain killers)	Y	N
Penicillin	Y	N	Aspirin	Y	N
Sulfa drugs	Y	N	Other substances or drugs	Y	N
Other antibiotics	Y	N	If yes, please list:		
If yes, please list:					
Tape/adhesives	Y	N			

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## Privacy Statement

Patient name: \_\_\_\_\_

Medical record #: \_\_\_\_\_

DOB: \_\_\_\_\_

SSN: \_\_\_\_\_

"I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way."

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Employee Signature: \_\_\_\_\_

## Patient Disclaimer

**To our patients:** This Patient Information Sheet is in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all patient information obtained is confidential. In order to comply with the requirements of the HIPAA and certain privacy regulations adopted pursuant to the act, the practice has adopted policies and procedures with respect to its use and disclosure of Protected Health Information. We understand that your protected health information is personal, and we are committed to protecting this information. In order to provide you with quality care and to comply with certain legal requirements, we create records of the care and services you receive from us.

In some cases, our fee for service is not covered by your insurance company even though we participate with them. We want our patients to be aware of the fact that they are responsible for any and all medical services performed and/or rendered by Deborah Pan, MD, and Javier J. Davila, MD, including and not limited to any previous prior authorizations and/or pre-certification received by your insurance company which your insurance may not cover or deny.

I understand that I (the patient and/or guarantor) am responsible for any charges incurred by the above named patient and promise to pay promptly the amount of such charges that are not paid by any insurance carrier, including co-payments due at the time of the visit for any such reason. Regardless of any insurance plan provisions regarding deductibles and/or co-insurances will become the responsibility of the patient/guarantor. I/We accept responsibility to pay the entire bill. In the event that this office needs to obtain legal assistance in the collection of any unpaid balance(s), I/we agree to pay costs and attorney fees, as allowable by law, and may obtain a photocopy of the agreement at the patient's request.

If you are not familiar with your insurance carrier coverage, we ask that you discuss your policy with your employer and/or insurance representative BEFORE charges are incurred.

**Please note: If the referral is not received, by either the patient or your primary care physician, at the time of your visit, the fee for service becomes you, the patient's, responsibility.**

Financially responsible person's signature: \_\_\_\_\_ Date: \_\_\_\_\_

AUTHORIZATION AND PATIENT CONSENT TO RELEASE MEDICAL RECORDS FOR BILLING PURPOSED IS GRANTED BY ME. I consent to the use and disclosure of my Protected Health Information (PHI) by this office for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of this Practice. I understand that diagnosis or treatment of me by the Practice may be conditioned upon my consent as evidence by my signature on this document.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICARE PATIENTS:** I request that payment under the Medicare/Metrahealth insurance program be made directly to Deborah Pan, MD and Javier J. Davila, MD on any bills for service furnished by their physicians during my lifetime. I understand that I may be held responsible for any portion of these bills after Medicare has paid the provider, or for charges Medicare does not cover.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I (the patient and/or guarantor) authorize this office to call my home (to leave a message via an answering device or to communicate with a family member), and/or have permission to call my place of employment to confirm any dates, times, appointments, or surgery protocol with their physician Deborah Pan, MD and Javier J. Davila, MD.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_