GORDLEY PLASTIC SURGERY, P.A.

# Patient Registration Form

Please Print

Date _______________

Patient ______________________________________________________________________
Last Name First Name Initial

Responsible Party (if patient is a minor) ______________________________________________

Street Address ______________________________________________________________

City ______________________ State _______ Zip _______________Sex ❑ M ❑ FAge _________

Birth Date _________________ ❑ Single ❑ Married ❑ Divorced

Email ____________________________________

Home Phone _____________________________ Mobile Phone _______________________________________

Social Security # _______________________________

Employed By ____________________________________________________________________

Business Address _____________________________________________________________

Occupation ____________________________________ Business Phone ______________________________

Check if you prefer to be contacted via ❑ Mobile phone❑ Home phone❑ Business phone ❑ email

Can we leave a message? ❑ Yes ❑ No

With whom may we share information about your account and medical records?

Name___________________________________

Relationship _____________________________ Phone ____________________________

Do you have Medical Insurance? ___________________

Name of Policy Holder _________________________________________________________________

Name of Insurance Company ___________________________________________________________

Policy # ____________________ Group # _________________________ Subscriber # _____________________

Name of Secondary Insurance Company (if any) _____________________________________________________

Policy # ____________________ Group # _________________________ Subscriber # _____________________

❑ Medicare # ___________________________________

How were you referred to our practice? ❑ Friend/Relative, if so, name: _________________________________

❑ Yellow Pages ❑ Physician, if so, name: _______________________________❑ Review-It Magazine

❑ Internet Search ❑ Hospital/ER referral ❑ Other? _____________________________________________

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or an agreement we might have made with insurer).

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I have received notice of this organization's privacy policies.

Signature: ___________________________________ Date: ____________________

GORDLEY PLASTIC SURGERY
PATIENT HEALTH HISTORY

PATIENT NAME:_______________________________________ DOB_____/_____/_____

Please answer all of the questions as accurately as possible.

Primary Care Doctor:_______________________________________________________________
Smoking (type & amount per day)__________ Alcohol (type and amount per week)______
If former smoker, date quit:_______________ Weight____________Height____________

Drug allergies and reactions ___________________________________________________________________

**List previous surgeries or major illnesses and dates:**
______________________________________________________________________________________
______________________________________________________________________________________
__

**List any medications you are taking, including non-prescription, vitamins and herbals:**
______________________________________________________________________________________
______________________________________________________________________________________
__

**Past Medical History**

***Have you ever had the following:***

| Condition | no | yes | Condition | no | yes | Condition | no | yes |
|---|---|---|---|---|---|---|---|---|
| Heart disease | no | yes | Cancer | no | yes | Stomach Ulcer | no | yes |
| Arthritis | no | yes | Glaucoma | no | yes | Kidney disease | no | yes |
| Rheumatic fever | no | yes | Asthma | no | yes | Thyroid disease | no | yes |
| Anemia | no | yes | AIDS or HIV+ | no | yes | Bleeding tendency | no | yes |
| Tuberculosis | no | yes | Stroke | no | yes | Mitral Valve prolapse | no | yes |
| Diabetes | no | yes | Hepatitis | no | yes | High blood pressure | no | yes |

**Review of systems**

***Have you had within the past year:***

| Condition | no | yes | Condition | no | yes | Condition | no | yes |
|---|---|---|---|---|---|---|---|---|
| Weight changes | no | yes | Swollen feet/ ankles | no | yes | Seizures | no | yes |
| Dry eyes | no | yes | Skin rash | no | yes | Joint/muscle pain | no | yes |
| Chronic cough | no | yes | Chronic diarrhea | no | yes | Swollen lymph nodes | no | yes |
| Chest pain | no | yes | Jaundice | no | yes | Easy bleeding | no | yes |

| Rapid heart beat | no | yes | Depression | no | yes | Easy bruising | no | yes |
|---|---|---|---|---|---|---|---|---|

**Family History:**

***Has any blood relative ever had the following:***

| Breast Cancer | no | yes | High blood pressure | no | yes | Kidney disease | no | yes |
|---|---|---|---|---|---|---|---|---|
| Melanoma | no | yes | Heart disease | no | yes | Depression | no | yes |
| Stroke | no | yes | Diabetes | no | yes | Problems with Anesthesia | no | yes |
| Sleep Apnea | no | yes | Heart Attack | no | yes | Blood Clots | no | yes |

**Women only**

| Date of Last Mammogram | |
|---|---|
| Bra Size (if applicable to visit) | |
| Number of pregnancies | |
| Number of live births | |
| Did you breast feed? | |

X_______________________________________ ______________________

Signature of patient or parent if minor Date

Gordley
Plastic Surgery

**Authorization for and Release of Medical Photographs/Slides and/or Videotapes**

Name: ______________________________

CONSENT TO TAKE PHOTOGRAPHS

I hereby authorize Kyle P. Gordley, M.D., and or his associates or licensees to take pre-operative, intra-operative, and post-operative photographs. I additionally consent to the use of any of my medical records including photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc as well as electronic digital networks, for purposes of medical education, patient education, or during lectures to medical groups.

**Patient Signature**________________________________ **Date**______________

**CONSENT OF PRIVACY PRACTICES FOR
PURPOSES OF PROTECTED HEALTH INFORMATION
FOR TREATMENT, PAYMENT, AND/OR HEALTHCARE OPERATIONS (HIPAA)**

I, __________________________, consent to the use or disclosure of my Protected Health Information by Kyle P. Gordley, M.D. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations by Kyle P. Gordley, M.D. I understand that diagnosis or treatment of me by Kyle P. Gordley, M.D. may be conditional upon my consent as evidenced by my signature on this document. The release of Protected Health Information with regards to my medical treatment may be sent by fax, telephone, mail or Email to other physicians, healthcare facilities or insurance companies**.**

I understand I have the right to request a restriction as to how my Protected Health Information is used or disclosed to carry out treatment, payment or health care operations of this practice. My treating physician at Gordley Plastic Surgery, P.A. is not required to agree to the restrictions that I, the patient, may request if the restriction falls within the exceptions to confidentiality by law. However, if Kyle P. Gordley, M.D. agrees to a restriction that I request, the restriction is binding on Kyle P. Gordley, M.D. as my treating physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that Kyle P. Gordley, M.D. has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health insurance plan, my employer or a health care clearinghouse. This relates to my past, present or future physical or mental health or condition that may identify me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review and request a copy of Kyle P. Gordley, M.D.'s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Kyle P. Gordley, M.D. The Notice of Privacy Practices for Kyle P. Gordley, M.D. is available at my request at any time . This Notice of Privacy Practices also describes my rights and Kyle P. Gordley, M.D. 's duties with respect to my Protected Health Information.

I have the right to request and be provided with a description of the procedures for exercising the following with respect to your Protected Health Information:

(i) Inspecting and copying;
(ii) Amending or correcting; and
(iii) An accounting of the disclosures of such information by Kyle P. Gordley, M.D.

Kyle P. Gordley, M.D. may change the policies and procedures relating to Protected Health Information at any time. Should the Protected Health Information policies change, a revised Notice will be available at Kyle P. Gordley, M.D.'s office. If you believe that there has been a violation of your Privacy Rights, a complaint may be filed with Kyle P. Gordley, M.D., at address;4850 W. Panther Creek Dr., Suite 105, The Woodlands, TX 77381 , or at (832) 813-5839. Further, a complaint may be filed with the U.S. Department of Health and Human Services.

**With my signature, I have been made aware of the Notice of Privacy Practices that is available at my request.**

________________________________
Signature

________________________________
Printed Name

Special Restrictions:

Date: ____________________________