Gregory O. Dick, MD, FACS
Plastic, Reconstructive & Cosmetic Surgery

PLEASE PRINT

PATIENT NAME _____ BIRTH DATE _____ SEX M ❑ F ❑
LAST NAME FIRST NAME MIDDLE

PATIENT'S ADDRESS _____
STREET CITY STATE ZIP CODE

HOME PHONE: _____ CELL PHONE: _____

PATIENT'S SS# _____ E-MAIL _____ AGE _____ MARITAL STATUS ❑ S ❑ M ❑ W ❑ D

PATIENT EMPLOYER _____

EMPLOYER ADDRESS _____ EMPLOYER PHONE NO. _____

SPOUSE _____ BIRTHDATE _____ PHONE _____

SPOUSE'S EMPLOYER _____

EMERGENCY CONTACT

NAME _____ RELATIONSHIP TO PATIENT _____ PHONE _____

INSURANCE INFORMATION

REFERRING PHYSICIAN _____

PRIMARY INSURANCE _____ POLICY NO. _____ GROUP _____ PLAN _____

Claims Office Address _____

Policy Holder's Name _____ Birthdate _____

SECONDARY INSURANCE _____ POLICY NO. _____ GROUP _____ PLAN _____

Claims Office Address _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION, CLAIM PAYMENT AUTHORIZATION

"I AGREE TO PRESENT ALL CLAIMS TO MY HEALTH INSURANCE CARRIER. I UNDERSTAND THAT I WILL REMAIN LIABLE FOR ALL PHYSICIAN'S CHARGES, AND IN THE EVENT OF COLLECTION OF PAST DUE ACCOUNTS. I UNDERSTAND THAT COLLECTION COSTS, COURT COSTS, AND REASONABLE ATTORNEY'S FEES, WILL APPLY TO ALL PAST DUE ACCOUNTS." I HEREBY AUTHORIZE AND DIRECT PAYMENT CHECK(S) FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY THE ABOVE NAMED PHYSICIAN(S) TO BE MADE DIRECTLY TO HIM.

_____ X _____
DATE PATIENT

PRIVACY NOTICE

Our copy of the HIPAA privacy notice is available at the front desk.

By signing this form, you acknowledge that Gregory O. Dick, M.D. has provided you access to a copy of our Privacy Notice, which explains how your health information will be handled in various situations. By law, we are required to have you sign this form on your first date of service with us.

Signature _____ Date

If you wish to authorize the release of your medical data to another person, please indicate this authorization.

Person _____

Phone _____

(OVER)

MEDICAL INFORMATION

Primary physician's name and address _____

_____

_____

Complaint (Reason for seeing Dr. Dick) _____

_____

PAST MEDICAL HISTORY

Have your ever had surgery? _____Yes _____No

Type	Year
_____	_____
_____	_____
_____	_____

DO YOU HAVE	YES	NO
Heart Disease	❑	❑
High Blood Pressure	❑	❑
Diabetes	❑	❑
Epilepsy	❑	❑
Thyroid Disease	❑	❑
Asthma	❑	❑
Kidney Disease	❑	❑
Broken Bones	❑	❑
Hepatitis	❑	❑
Cancer	❑	❑
Anemia	❑	❑
Bleeding tendency	❑	❑
Easy bruising	❑	❑
TB	❑	❑
Bronchitis	❑	❑
Emphysema	❑	❑
Shortness of breath	❑	❑

ARE YOU ALLERGIC TO:

Penicillin	❑	❑
Novocaine	❑	❑

Other drugs (please list)

_____

_____

LIST MEDICATIONS YOU TAKE:

_____

_____

_____

_____

_____

DO YOU HAVE	YES	NO
Chest Pain	❑	❑
Dizzy Spells	❑	❑
Ulcers	❑	❑
Glaucoma	❑	❑
Nervous Condition	❑	❑
Depression	❑	❑
AIDS/HIV	❑	❑

HAVE YOUR EVER HAD:

Rheumatic fever	❑	❑
Cold Sores	❑	❑

DO YOU TAKE:	❑	❑
Blood thinner medication	❑	❑
Heart medication	❑	❑
High blood pressure med.	❑	❑
Diuretics (water pills)	❑	❑
Aspirin	❑	❑
Steroids	❑	❑

DO YOU SMOKE?	❑	❑
Have you smoked in the past?	❑	❑
DO YOU DRINK ALCOHOL?	❑	❑

FAMILY HISTORY:

Cancer	❑	❑
Diabetes	❑	❑
Heart Disease	❑	❑
High Blood Pressure	❑	❑
Bleeding Disorder	❑	❑

HAVE YOU HAD A PROBLEM WITH ALCOHOL ❑ OR DRUGS ❑ NOW OR IN THE PAST?

PLEASE LIST ANY ADDITIONAL MEDICAL PROBLEMS:

_____

_____

THANK YOU!