

Date \_\_\_\_\_

## PATIENT INFORMATION FORM

Name \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ Home phone(\_\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone(\_\_\_\_\_) \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Married  Widowed  Single  
 Separated  Divorced  Partner

Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Phone(\_\_\_\_\_) \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone(\_\_\_\_\_) \_\_\_\_\_

### ~PRIMARY INSURANCE~

Person responsible for account \_\_\_\_\_ Relation to patient \_\_\_\_\_

DOB \_\_\_\_\_ SS# \_\_\_\_\_ Phone(\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_ Work# \_\_\_\_\_

Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

### ~ADDITIONAL INSURANCE~

Subscriber Name \_\_\_\_\_ Relation to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Phone(\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone(\_\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

### ~Assignment and Release~

I certify that I, and/or my dependent(s) have insurance with \_\_\_\_\_ and assign directly to

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named physician may use my health care information and disclose such information to the above-named Insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of patient, parent, or guardian \_\_\_\_\_

Date \_\_\_\_\_



2. List any previous surgeries including dates and procedures: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Allergies: List any allergies to medications, foods, soaps, etc.  
Allergy \_\_\_\_\_ What kind of reaction? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Have you had previous blood transfusions? Yes \_\_\_\_\_ No \_\_\_\_\_ When \_\_\_\_\_  
If yes, have you ever had a transfusion reaction? Yes \_\_\_\_\_ No \_\_\_\_\_

5. Are you currently pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_  
Are you breast-feeding? Yes \_\_\_\_\_ No \_\_\_\_\_

6. List all prescription meds that you are currently taking including: herbal supplements & birth control.

<u>Medication Name</u>	<u>Dose (Mg or ML)</u>	<u>How Often?</u>	<u>Why Taking?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. Have you taken any steroid, cortisone or prednisone therapy in the last 12 months?  
Yes \_\_\_\_\_ No \_\_\_\_\_

8. Have you had radiation therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

9. Do you use tobacco or smoke? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, what type? Cigarette \_\_\_\_\_ Pipe \_\_\_\_\_ Chew \_\_\_\_\_  
Have you ever previously smoked? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, how many years? \_\_\_\_\_  
How many packs per day of cigarettes did you smoke? \_\_\_\_\_

10. Do you drink caffinated beverages? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, amount per day? \_\_\_\_\_

11. Do you drink alcoholic beverages? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, what type and how many drinks per day? \_\_\_\_\_  
Have you ever been in treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

12. Do you use or have you ever used IV or "street" drugs? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, what type and amount? \_\_\_\_\_

13. Have you previously had anesthesia? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, what type of anesthesia? General \_\_\_\_\_ Local \_\_\_\_\_ Spinal \_\_\_\_\_ Epidural \_\_\_\_\_ Other \_\_\_\_\_  
If yes, have you had any problems with anesthesia? \_\_\_\_\_  
Have you or a blood relative ever had an allergic reaction or history of complications while under the  
Influence of anesthesia? If so, please explain; \_\_\_\_\_  
\_\_\_\_\_

14. Who is your Primary Care Physician? \_\_\_\_\_

The facts and information that I have given on this form are accurate to the best of my knowledge.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**LINCOLN AESTHETIC & RECONSTRUCTIVE SURGERY**

**Mitchell J. Henry, M.D., D.D.S.  
Joseph C. Camarata, M.D., D.M.D.  
2222 South 16<sup>th</sup> Street, Suite 300  
Lincoln NE 68502  
402-435-0044**

**PATIENT FEE AGREEMENT**

I understand that all professional services rendered are charged to and are the responsibility of the patient. Although Lincoln Aesthetic and Reconstructive Surgery will complete insurance forms to expedite insurance carriers payments, I understand that I am responsible for all fees incurred, including all charges not covered by the insurance carrier for any reason. If my insurance carrier requires by contract a "co-pay" payment to be made by the patient, I will pay that co-pay payment on the day that service is provided.

I understand that it is my responsibility to complete payment in full for services provided within 60 days of the date of service. If after 60 days payment is not made in full, 16% interest per annum will be added to my balance each month until the account is paid in full. This also includes any finance charges that have been added due to an account being delinquent. In the event that I am due a refund, after my insurance company has completed payment; I understand that the refund will be done within 60 days of the date of payment, and that the refund will be given in the manor in which I paid.

Date: \_\_\_\_\_ Signature of Patient or Guarantor: \_\_\_\_\_

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I hereby authorize Lincoln Aesthetic and Reconstructive Surgery to furnish information to my insurance carrier(s) concerning my illness and treatments. I hereby assign to Lincoln Aesthetic and Reconstructive Surgery, all payments for medical services rendered to my dependent or myself. I understand that I am responsible for all charges for services rendered that are not covered by insurance and I will pay such charges according to the Patient Fee Agreement.

Date: \_\_\_\_\_ Signature of Patient or Guarantor: \_\_\_\_\_

**MEDICAL RECORDS RELEASE**

I hereby authorize Lincoln Aesthetic and Reconstructive Surgery to release any information that may assist in my medical or dental care. This may include medical records such as pathology reports, culture reports, progress notes, x-ray and operative reports. I also give permission for Lincoln Aesthetic and Reconstructive Surgery to discuss my treatment with a physician or dentist in the event that it may be deemed necessary to provide me with medical and dental care. This release also includes release of information to physical or occupational therapy and communication with my therapist.

Date: \_\_\_\_\_ Signature of Patient or Guarantor: \_\_\_\_\_

LINCOLN AESTHETIC & RECONSTRUCTIVE SURGERY  
2222 SOUTH 16<sup>TH</sup> STREET SUITE 300  
LINCOLN NE 68502

**DETAILED NOTICE OF PRIVACY PRACTICES**

**Changes to this notice** - We reserve the right to make changes to this notice of privacy practices. The revised practices will be implemented as of the effective date on the revised notice and will apply to all medical information whether it was collected before or after the date of revision. The revised notice will be posted in our office and copies will be available at the front desk for review.

**Complaints** - You may file a complaint regarding our policies and procedures or report non-compliance with our policies and procedures to our Privacy Officer at the above address. You may also file a complaint with the Secretary of Health and Human Services. We will not penalize you in any way for filing such a complaint.

If you would like a copy of our privacy practices, requests may be made at the front desk.

If you have any questions about this notice, please contact:

Privacy Officer	Amy Bednar
Practice Name	Lincoln Aesthetic and Reconstructive Surgery, PC
Address	2222 S 16 <sup>th</sup> Street, Suite 300 Lincoln, NE 68502
Telephone number	402 435-0044
Fax number	402 435-7010

I verify that I have read and understand the privacy practices of Lincoln Aesthetic & Reconstructive Surgery.

Effective Date of Notice: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

\_\_\_\_\_  
(Signature of patient or guardian)

\_\_\_\_\_  
(Date)