Houston Plastic & Reconstructive Surgery

Patient Registration Form

Name (Last)_____ (First)_____ (Middle Init.)_____

Address(Street)_____ (City)_____ (State)___ (Zip)_____

Home#_____ **Cell#**_____ **Work#**_____

***I authorize the office staff to leave messages for me on: Home# Y / N Work# Y / N Cell# Y / N**

Birthdate_____ **Social Sec.#**_____**Sex**____**Marital Stat.**_____**Spouse Name**_____

Employer_____ **Employers Address**_____

E-Mail Address_____

May we e-mail you specials/promotional offers? Y / N Appointment Reminders? Y / N
Race: Asian Black Caucasian Hispanic Other Ethnicity: Hispanic Non-Hispanic
How did you hear about our facility? _____

Name of Referring Physician/Patient:_____

Emergency Contact _____ **Phone#**_____

Responsible Party *if* other than "Self" (Name of the person responsible for payment if other than the patient):

Name (Last)_____ (First)_____ (Middle Init.)_____

Address(Street)_____(City)_____(State)_____(Zip)_____

Home #_____**Cell** _____**Work** _____

Employer_____**EmployersAddress**_____

Date of Birth_____ **Social Security#**_____ **Sex**_____

Please note: Complete the Below *Only* if We Are Filing to Your Insurance

Primary Insurance:_____ **Relation to Insured:**_____

Member ID#_____ **Group #**_____

Insured Name:_____ **Insured Date of Birth:**_____

Secondary Insurance:_____ **Relation to Insured:**_____

Member ID#_____ **Group #**_____

Insured Name:_____ **Insured Date of Birth:**_____

I understand Houston Plastic & Reconstructive Surgery accepts medical insurance for medically related issues only. I am being treated for a medical diagnosis and I will provide my insurance card to copy. I hereby assign benefits and authorize payment directly to Houston Plastic & Reconstructive Surgery, for any medical and/or surgical treatment issued.
I authorize the release of any medical information needed during the course of my treatment to determine these benefits. This authorization shall remain valid until I revoke this authorization with written notice.

I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature: _____ **Date:** _____

MEDICAL INFORMATION
Page 1

NAME: _____ **DATE:** _____

Date of Birth: _____ **Age:** _____ **Height:** _____ **Weight:** _____ **Blood Type:** _____

Marital Status: (circle) M S D W **Work: (circle) FT PT Unemployed Retired Student**

Reason(s) for consultation: _____

_____

Have you consulted with another doctor? YES / NO
Who is your family doctor (the doctor you see for most of your problems)?

Name _____ **Phone number:** _____

When was your most recent physical checkup? _____ **EKG?** _____ **Chest X-ray?** _____

Please list all medications, prescriptions and non-prescriptions, you are currently taking or take on a routine basis (include dosage):

_____

_____

_____

_____

_____

Medication Allergies: CODEINE SULFA MORPHINE PENICILLIN MYCINS TETRACYCLIN
OTHER (Please specify) _____

Are you allergic to any topical preparations? TAPE BETADINE
OTHERS (please specify): _____

Name & Address & Phone Number of Pharmacy: _____

_____

Exercise: Circle ONE:

None, sedentary, Occasional Light Activity
Occasional Aerobic **Occasional Weight Lifting/Resistance**
4 times or more per week Light Activity **4 times + per week Aerobic**
3 times or more Weight Lifting/Resistance

MEDICAL INFORMATION PAGE 2

Have you ever had any of the following conditions? Check all that apply:

CONDITION: Details	YES	NO
Bleeding Disorder		
Blood Clots		
Heart Disease		
Cancer		
Stroke		
Anxiety		
Asthma		
COPD		
Backache		
Diabetes Type 1		
Esophageal Reflux		
Hypercholesterolemia		
Hyperlipidemia		
Hypertension		
Thyroid Disease		
Obesity		
Weight Change over the past year? CIRCLE ONE: None, Gained 0-5 lbs, Lost 0-5 lbs., Gained 5-10 lbs., Lost 5-10 lbs., Gained 10-20 lbs., Lost 10-20 lbs., Gained 20+ lbs., Lost 20+ lbs.		
Males: Do you have difficulty urinating?		
Females: Do you have fibrocystic or other breast changes?		
Last mammogram: If done list month/year _____		
Pregnant Now? Number of pregnancies?		
Children: Son #____ Ages: Daughters#_____ Ages:		
Surgical History:		
Date of Surgery: Procedure:		
Date of Surgery: Procedure:		
Date of Surgery: Procedure:		
Date of Surgery: Procedure:		
Date of Surgery: Procedure:		
Date of Surgery: Procedure:		
Date of Surgery: Procedure:		
Do you smoke? (even a little) How much/how many years?		
Desire to Quit Smoking?		
Do you now or have you ever used alcohol? CIRCLE ONE: Never, Rare, Daily, Weekly, A few times a Week, Monthly		
Do you now or have you ever used illicit drugs? CIRCLE ONE: Never, Rare, Daily, Weekly, A few times a Week, Monthly		
Do you use Caffeine? Never, Rare, Daily, Weekly, A few times a Week, Monthly		
Do you use products containing aspirin or ibuprofen on a regular basis (How often?)		

MEDICAL INFORMATION PAGE 3

Family History—Please indicate if anyone in your immediate family has had any of the following conditions:

	Father	Mother	Brother(s)	Sister(s)	Children
Age					
Autoimmune					
Deceased					
No Health Conditions					
Arthritis					
Asthma/Allergies					
Bleeding Tendency					
Colorectal Cancer					
Alcoholism					
Cancer					
Coronary Disease					
Heart Attack					
Reaction to Anesthesia					
Tuberculosis					
Blood Clots					
Pulmonary Embolism					
Stroke					
Genetic Disorder					
COPD					
Mental Illness					
Diabetes Type 2					
Diabetes Type 1					
Hypertension					
Hyperlipidemia					
Thyroid Disease					
Other					

Clayton L. Moliver, M.D., F.A.C.S. & Kendall R. Roehl, M.D.
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I acknowledge that Clayton L. Moliver, M.D., P. A. provided me with a written copy of the Practice Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

You may be contacted by the office of Clayton L. Moliver, M.D., P.A. to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

May we contact you at home? Yes No (circle one)
May we contact you at work? Yes No (circle one)
May we contact you via cell phone? Yes No (circle one)
May we leave a voice mail at all of the above? Home: Yes No
Work: Yes No Cell: Yes No
May we text you appointment reminders? Yes No (circle one)
May we contact you via email? Yes No
If "Yes", may we send you special offerings via email? Yes No
Can a message be left using our name and what the call is in reference to? Yes No

Is there anyone we can leave a message with? Yes No (If yes, please list names)

_____ _____

Would you like to authorize an individual as your personal representative? This person would have the authority to schedule, confirm or change appointments only.
Yes No (If yes, please list first and last name)

_____

_____ _____
Patient Signature Date

_____ _____
Personal Representative Signature (if applicable) Relationship to Patient