

Patient Information

Please present health insurance card and co-payment to front desk.

PATIENT Information: (PLEASE PRINT)

Today's Date: ____ / ____ / ____

Last Name _____ First _____ M.I. _____

Address _____ City _____ State _____ Zip _____

Home # () _____ Cell # () _____ Work # () _____

Soc. Sec. #: _____ Birth Date _____ Age _____ Sex: M F

Employer Name _____ Employer Address _____

Marital Status: Married Single Widowed Separated Divorced

Race: African-American Asian Caucasian Hispanic Other: _____

PLEASE SPECIFY

Preferred Contact: Home # Cell/Mobile # Work # E-Mail Other: _____

PLEASE SPECIFY

YOUR Physician:

(MD name)

(address)

(phone)

Incase of an EMERGENCY notify?

Full Name: _____ Phone: () _____ Relation: _____

REFERRED BY? _____ **How did you hear about us?** Friend/relative _____

(NAME)

(NAME)

Our Patient _____ Phone Book Newspaper Ad Radio Postcard Staff member _____

(NAME)

Andrea, Ericka, Erin, Lori, Michelle, Doctor

INTERNET: Our Website Smartlipo.com SuperPages.com Consumer Guide to Plastic Surgery

LookingYourBest.com LoveYourLook.com TV _____ Other Internet Service _____

(EXPLAIN)

(EXPLAIN)

E-Mail address: _____ include if you would like to be updated on what's happening here at the *Center For Plastic Surgery*, such as, birthday discount, office seminars, newsletters, specials and more.

PARENT / GUARDIAN Information - Must be completed if patient is under 18 years old.

Last Name _____ First _____ M.I. _____

Address _____ City _____ State _____ Zip _____

Home Phone () _____ Work Phone () _____ Relation to Patient _____

Birth Date _____ Age _____ Sex: M F

Employer Name _____ Employer Address _____

Is condition related to: Employment Y or N, Auto Accident Y or N, Other Accident Y or N
Relation to Patient

PRIMARY INSURANCE: self parent spouse other

Insured's Name _____ Birth Date _____

Policy/ID No. _____ Employer Name/Address _____

Relation to Patient

SECONDARY INSURANCE: self parent spouse other

Continue to back page...

Dina A. Eliopoulos, MD
Center for Plastic Surgery
10 Research Place, Suite 202, North Chelmsford, MA 01863

PRIVACY POLICY ACKNOWLEDGEMENT

My signature below acknowledges that I have been made aware of Dina Eliopoulos, MD privacy policies as mandated by HIPAA. I have been given the opportunity to read and ask questions regarding Dina Eliopoulos, MD's privacy policies. A copy of this policy has been mailed to me or given to me upon my first visit. This acknowledgement will remain a permanent part of my medical record. **I acknowledge having received a copy of Dr. Dina Eliopoulos' Notice of Privacy Practices.**

Patient /Parent/Guardian Signature

Patient Name

Date

ASSIGNMENT OF INTEREST

I authorize direct insurance benefit payment to Dina Eliopoulos, MD for any medical expense incurred by me and/or any covered dependent. This assignment will remain in effect until revoked by me in writing. I also authorize release of any medical information required to process insurance claims. I further understand that I am financially responsible for all balances remaining after insurance benefit determination.

Patient /Parent/Guardian Signature

Date

OFFICE BILLING POLICIES

Please take a moment to become familiar with our billing policies. If you have any questions please do not hesitate to ask our office staff, we will be more than happy to assist you (978-275-9440).

- Payment in full is required at the time of service unless other arrangements have been made.
- The person who is receiving our services has the sole financial responsibility for our charges. Exception: Minors (under 18 year of age). The custodial parent/guardian would assume full financial responsibility.
- Dina Eliopoulos, MD will file third party medical claims directly for the patient assuming that complete insurance information and assignments have been provided. Co-pays are due on the date of service. Payment of the entire bill remains the responsibility of the patient or custodial parent/guardian. Payment of any balances remaining after insurance submission also remains the responsibility of the patient or custodial parent/guardian.
- Referral policy: It is the patient's or custodial parent/guardian's direct responsibility to provide Dina Eliopoulos, MD with a current/valid referral from his/her primary care physician or his/her health insurance carrier. Referral must be received by the date of service or the patient or custodial parent/guardian will be held financially responsible for the cost of the visit.

Your signature below acknowledges that you have read and understood Dina Eliopoulos, MD billing policies.

Patient /Parent/Guardian Signature

Date

CONSENT FOR PHOTOGRAPHS

I understand and approve that any photographs and/or videotapes taken as part of the procedure/surgery will become the property of my physician and or medical records. I also consent to the use of such photographs as evidence in a legal proceeding or for educational or research purposes or for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

Patient /Parent/Guardian Signature

Date

Patient Name: _____ **Birth Date:** ____/____/____ **Date:** ____/____/____

Reason for this visit: _____

Primary Care Doctor: _____
(Name) (Address)

When was your most recent physical check up? _____
(Date)

Allergies:
 List any drug related allergies or intolerances, along with reaction to such medicines: _____

Are you sensitive to adhesive tape/suture material No ___ Yes ___

Medications/Drugs:
 List all medications you are now taking and their dosage(s) including non-prescription drugs, birth control pills, diuretics (water pills) blood pressure or heart medications, vitamins and herbals, etc.: _____

Previous Surgery/Operations (Please list below)

<u>Operation</u>	<u>Year</u>	<u>Hospital</u>	<u>City</u>	<u>Surgeon's Name</u>	<u>Anesthesia (local/general)</u>

Past Medical History:
 List all medical illness(s) or hospitalizations with approximate date(s): _____

Have you ever had the following?

	No	Yes		No	Yes		No	Yes		No	Yes
Cong. heart failure			Kidney disease			GERD / ulcer			Thyroid disease		
Heart disease			Bleeding disorder			Anemia			Seizures		
Pacemaker			Blood clots			Hernia(s)			Mitral valve prolapse		
High blood pressure			Blood transfusion			Acute infections			Cold Sores		
Stroke			Diabetes			AIDS or HIV+			History of Accutane		
Lung disease			Cancer			Hepatitis			Bad reaction to anesthetics		
Asthma			Glaucoma			Liver disease			Psychiatric disorder/depression		
Arthritis			Intestinal disorder			GYN problems			Keloid / thickened scars		

Do you smoke? No ___ Yes ___

What is your approximate daily consumption of the following: (below)

If yes, what type & amount per day: _____

Coffee or tea _____ Alcohol _____

If former smoker, date quit: _____

Tobacco _____ Drug Use _____

Indicate if drugs or alcohol ever posed a dependency problem for you: _____

Your Occupation: _____

Height: _____ Weight: _____ Weight loss or gain in past year _____ lb(s). Loss Gain

Do you have now or have you had?

	No	Yes		No	Yes		No	Yes		No	Yes
Weight change			Rapid heart beat			Easy bleeding			Jaundice		
Dry eyes			Swollen feet / ankles			Easy bruising			Skin rash		
Chronic cough			Shortness of breath when walking			Swollen lymph nodes					
Chest pain			Chronic diarrhea			Joint or muscle pain					

Women Only:

Date of last period: _____ Date of last Mammogram: _____
 Are you pregnant? No ___ Yes ___ Breast lump or discharge? No ___ Yes ___
 Are you lactating? No ___ Yes ___ Do you take birth control pills or hormone replacement? No ___ Yes ___
 Number of pregnancies: _____ Did you breast feed? No ___ Yes ___
 Number of children and Age: _____

Has any blood relative had:

	No	Yes		No	Yes		No	Yes	
Cancer			Bad reaction to anesthesia			Heart disease			
Breast cancer			Melanoma			High blood pressure			
Diabetes			Lung disease			Blood or Bleeding disorder			Explain:
Stroke			Kidney disease			Blood clotting disorder			Explain:

Pertinent Preoperative Information

	No	Yes
Have you ever had a bad reaction to a local anesthetic, Novocain, or Epinephrine, etc. such as heart racing, feeling jittery, etc.?		
Have you ever reacted badly to being put to sleep for surgery?		
Have you required unusually large amounts of local anesthetic for medical or dental procedures?		
Are you a slow or poor healer?		
Do you have any skin disease, hives, eczema or rash?		
Do you have frequent infections or boils?		
Have you taken steroid medications, cortisone, or adrenocorticotrophic hormone (ACTH)?		
Does your religion prohibit blood transfusions?		

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X _____ (Signature of patient or parent if minor) _____ (Date)

Dear Patient: Our goal is to respond to all of our patient's needs and to provide the highest quality of care. In order to provide the information and services you desire on the health and appearance of your skin, we invite you to complete the following questionnaire:

Please check all areas of concern to you:

- Fine lines and wrinkles
- Lines around my eyes
- Lines between my eyes
- Lines on forehead
- Lines under eyes
- Puffy eyes
- Dry skin
- Oily skin
- Acne
- Crease nose to corner of mouth
- Frown on corner of mouth
- Age spots/sun damage/brown spots
- Red, blotchy skin
- Excess skin above eyes
- Looking tired
- Thin lips
- Leg veins
- Laser hair removal

Plastic surgery procedure(s) of interest:

- Facelift
- Eyelid
- Liposuction / Smartlipo Laser Body Sculpting
- Breast augmentation / Breast implants
- Breast lift
- Breast reduction
- Body contouring after weight loss
- Tummy tuck / Abdominoplasty
- Other: _____