STATESBORO PLASTIC SURGERY

(912) 681-3330

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

Race _____ Ethnicity _____ Language _____

Age _____ Birthdate _____ SS# _____ Sex ❒ Female ❒ Male

Marital Status ☐ Single ☐ Married to: _____ ☐ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ☐ Yes ☐ No

Address _____
Street & Suite # City State Zip

Emergency Contact
(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

Please list your Primary Care Provider _____

How did you hear about us?

☐ Google ☐ Facebook ☐ Instagram ☐ Driving by ☐ Seminar ☐ Doctor _____

☐ Friend/Relative _____ ☐ Website _____ ☐ Other _____

Parent Information if the patient is a minor under the age of 18

Guardians Name _____ Date of Birth _____ Phone Number _____

Guardians Employer _____ Work # _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Bisseck to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Bisseck and myself. I futher understand that any portion of the bill that the insurance company or responsible party does not cover is my responsibility. For any disputes of financial policy, the patient waives his/her right to privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) guidelines. I hereby agree that if my bill has to be turned over to a third party collection agency for non payment, there will be a collection fee added to my bill. This is pursuant to Georgia Statutory Law "O.C.G.A. -13-1-11".

Signature _____ **Date** _____

STATESBORO PLASTIC SURGERY – HISTORY & PHYSICAL

Name:	Date:
What are you being seen for today?(Please be specific)	
If this is a result of an accident, give the date of injury.	
--Please describe how the accident occurred.	

Are you allergic to any medications? NO ☐ YES ☐ Please List:

PAST MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
Diabetes	☐	☐	Osteoporosis	☐	☐	Blood Clots	☐	☐
Chest Pain/Angina	☐	☐	Asthma	☐	☐	Tuberculosis	☐	☐
High Blood Pressure	☐	☐	Stroke/CVA/TIA	☐	☐	Depression	☐	☐
Heart Disease	☐	☐	Seizures	☐	☐	Congestive Heart Failure	☐	☐
Heart Attack	☐	☐	HIV/AIDS	☐	☐	Thyroid Disease	☐	☐
High Cholesterol	☐	☐	Hepatitis	☐	☐			
Pacemaker	☐	☐	Stomach Ulcer	☐	☐	Other (please list below)		
Headaches	☐	☐	Liver Disease	☐	☐	_____		
Kidney Stones	☐	☐	Heart Palpitations	☐	☐	_____		
Kidney Disease	☐	☐	Arthritis	☐	☐	_____		
Cancer _____			Heart Surgery	☐	☐	_____		
Skin Cancer	☐	☐	COPD	☐	☐			

CURRENT MEDICATIONS

☐ **CHECK HERE IF YOU ARE NOT ON ANY MEDS**

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____
11._____

ROS		Please check all CURRENT positive findings
Constitutional		☐ Weight loss ☐ Fevers ☐ Chills ☐ Poor appetite ☐ Fatigue ☐ Weight gain ☐ Insomnia ☐ Night sweats
Eyes		☐ Blurry vision ☐ Eye pain ☐ Eye discharge ☐ Eye redness ☐ Decrease in vision ☐ Dry eyes ☐ Double vision
ENT		☐ Sore throat ☐ Hoarseness ☐ Ear pain ☐ Hearing loss ☐ Ear discharge ☐ Nose bleeds ☐ Tinnitus ☐ Sinus problems
Cardiovascular		☐ Chest pain ☐ Palpitations ☐ Rapid heart rate ☐ Heart murmur ☐ Poor circulation ☐ Swelling in the legs or feet
Respiratory		☐ Shortness of breath ☐ Chronic cough ☐ Coughing up blood ☐ History of Tuberculosis ☐ Excess sputum production
Gastrointestinal		☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Blood in the stool ☐ Frequent heartburn ☐ Trouble swallowing
Skin		☐ Rash ☐ Hives ☐ Hair loss ☐ Skin sores or ulcers ☐ Itching ☐ Skin thickening ☐ Nail changes ☐ Mole changes
Musculoskeletal		☐ Joint pain ☐ Muscle aches ☐ Frequent leg cramps ☐ Muscle weakness ☐ Bone pain ☐ Joint swelling ☐ Back pain
Endocrine		☐ Goiter ☐ Heat intolerance ☐ Cold intolerance ☐ Increased thirst ☐ Change in skin pigment ☐ Excess sweating
Neurological		☐ Seizures ☐ Tremors ☐ Migraines ☐ Numbness ☐ Dizziness/Vertigo ☐ Loss of balance ☐ Slurred speech ☐ Stroke
Psychiatric		☐ Anxiety ☐ Depression ☐ Alcohol or drug dependence ☐ Suicidal thoughts ☐ Panic attacks ☐ Use of anti-depressants
Genitourinary		☐ Increased urinary frequency ☐ Blood in the urine ☐ Incontinence ☐ Painful urination ☐ Urinary retention ☐ FrequentUTIs
Hem/Lymphatic		☐ Low blood count ☐ Easy bruising ☐ Swollen lymph nodes ☐ Transfusions ☐ Prolonged bleeding ☐ Blood clots
Allergic/Immun		☐ Allergic reactions ☐ Hay fever ☐ Frequent infections ☐ Hepatitis ☐ HIV positive ☐ Positive tuberculin skin test (PPD)

SOCIAL HISTORY:

Marital Status _____ Occupation _____ ☐ **Non-Smoker** ☐ **Ex-Smoker** ☐ **(how long ago quit?)** _____

☐ **Current Smoker** ☐ **Light Smoker** ☐ **Heavy Smoker (How many packs/day and how long?)**_____

Alcohol consumption: ☐ Never ☐ Occasional ☐ Frequent Illegal drugs use: ☐ Yes ## ☐ No .....

STATESBORO PLASTIC SURGERY – HISTORY & PHYSICAL

Patient Past Surgeries/Hospitalizations (IF NONE PLEASE WRITE NONE ON THE FIRST LINE)

Surgery/Hospitalization	Date	Anesthesia complications	Notes

Female Questions

	Yes	No	N/A	Details
Do you have children? I yes, please list number of pregnancies & ages of children.	☐	☐	☐	
Do you have regular periods?	☐	☐	☐	
Are you going through menopause?	☐	☐	☐	
Are you pregnant or lactating?	☐	☐	☐	
During pregnancy, did you ever get hyperpigmentation or masking?	☐	☐	☐	
Have you had any mammograms?	☐	☐	☐	Results:
Current Bra Size				

Patient Family History

	YES	Family Member
Pt denies any contributing family hx	☐	
Abnormal Bleeding	☐	
Abnormal Clotting	☐	
Anesthesia Problems	☐	
Autoimmune Disorder	☐	
Brain Tumor	☐	
Breast Cancer	☐	
Cleft Lip	☐	
Cleft Palate	☐	
Diabetes	☐	
Drug Allergies	☐	
Endocrine Disease	☐	
Hearing Loss	☐	
Heart Disease	☐	
Hemophilla	☐	
High Blood Pressure	☐	
Kidney Disease	☐	
Liver Disease	☐	
Lung Cancer	☐	
Malignant Hyperthermia	☐	
Other Cancer	☐	
Ovarian Cancer	☐	
Prostate Cancer	☐	
Skin Cancer	☐	
Skin Disease	☐	
Substance Abuse	☐	

Body Size	Details
Height (ft)	
Height (in)	
Weight (lbs)	
Recent weight changes	

Statesboro
Plastic Surgery

PAYMENT POLICIES FOR COSMETIC PATIENTS & PROCEDURES

Before we can schedule you for surgery, a 30% deposit must be paid. This deposit is *NON-REFUNDABLE*.

The total cost of the procedure must be paid ***NO LATER THAN 1 WEEK PRIOR TO YOUR SURGERY***. If we have not received your payment by that time, your procedure will be cancelled and your deposit will not be refunded. Payment cannot be made on the day of surgery.

If you are not able to mail us your payment or come to the office, we can take your credit card over the phone. There will be a 3% fee added to the charge for all credit card payments over a $1,000.00.

No Show/Late Cancellation Policy

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case-by-case basis.

A prepayment of $100.00 will be required for all initial Cosmetic Consultation appointments and is Non-refundable if less than 24 hours' notice is given.

A charge of $50.00 will be assessed for each no show or late cancellation for all cosmetic appointments if less than 24 hour notice is given.

By signing below I am agreeing that I have read and understand the above information. I completely understand the payment policies and procedures described to me by the office staff as well as in the document. I have no remaining questions about when payment is due and what types of payments are accepted.

_____ _____

Signature Date

1402 Brampton Ave * Statesboro, Georgia 30458 * phone 912-681-3330 * fax 912-681-3303

Statesboro
Plastic Surgery

Picture Release

I am a patient of Statesboro Plastic Surgery. I give my permission to Statesboro Plastic Surgery to utilize my preoperative and postoperative photographs to be shown for one or more of the following purposes: (i) my medical record, (ii) promotional brochures, (iii) patient education materials, (iv) instructional videos, (v) medical journals, (vi) websites, (vii) social media (the practice and individual staff members), and (viii) other formats.

I hereby grant permission for the use of any of my medical records including illustrations, 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.

By making this authorization, I understand that:

- I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- I will not be paid in any way for the use of pictures/digital images or videos of me.
- The information released in response to this authorization may be re-disclosed to other parties.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
- This authorization shall be in force and effect until revoked by me in writing.

Signature: _____ Date: _____

Statesboro
Plastic Surgery

Online Communication

Online communication is a form of communication using “secure” Web sites or e-mail applications that apply appropriate encryption technology designed to protect the transmission of confidential information
The details of online communication have been explained to me in terms I understand.
Alternative methods of communication (telephone, in-person, mail) are still available to me.
I understand that all medical communications carry some level of risk. While the likelihood of risks associated with the use of online communication in a secure environment is substantially reduced, the risks are nonetheless real and very important to understand. These risks include but are not limited to:

- *It is easier for online communication to be forwarded, intercepted, or even changed without my knowledge.*
- *Online communication is easier to falsify than handwritten or signed hard copies. Backup copies may exist on a computer or in cyberspace, even after both of us have deleted our copies.*
- *It is my responsibility to use a secure network.*
- *Online communications become part of my medical record.*

I agree to take precautions to keep online communication confidential, including but not limited to the following:

- *I will keep my password confidential.*
- *I will store messages on a secure computer.*
- *I will not leave messages on my screen for others to read.*
- *I will update my contact information as soon as it changes.*

I understand that I am responsible for taking steps to protect myself from unauthorized use of online communication. Statesboro Plastic Surgery is not responsible for breaches of confidentiality caused by an independent third party or me.
I agree to follow the procedure Statesboro Plastic Surgery implements to allow SPS to verify my identity in connection with online communication. I acknowledge that failure to comply with these procedures may terminate our online communication. I understand that online communication cannot be used for emergencies or time sensitive matters
I understand that online communication cannot be used to communicate highly sensitive medical information, such as treatment or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).
I have informed Statesboro Plastic Surgery of any information I do not want transmitted via online communications.
I understand that it is my responsibility to determine if an unanswered online communication was received.
I acknowledge that I have read and fully understand this consent form, including the risks associated with the online communication. Statesboro Plastic Surgery has answered all of my questions.

Signature: _____ Date: _____

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