

HOW DID YOU FIND OUT ABOUT US:

- Phone book Previous Patient(please list below) Physician(please list below)
- Community Living Magazine loveyourlook.com implantinfo.com
- H-Texas Magazine Internet _____ (please list source) Newspaper

PLEASE LIST REFERRAL NAME/LOCATION: _____

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ◆ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment either directly or indirectly.
- ◆ obtain payment from third-party payers
- ◆ conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the opportunity review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____ DATE: _____
signature of patient/person responsible for account

I understand that I am responsible for all fees. I understand the office of Philip J. Straka, M.D. is not currently accepting new insurance patients and will not file any insurance claims on my behalf. I understand that all surgical fees are due prior to surgery being performed.

_____ DATE: _____

Please list those people with whom we may discuss/release medical information to:

HEALTH HISTORY

Patient Name: _____ Date: _____

Age: _____ Birthdate: ____/____/____ HT: _____ WT: _____ Marital status: M S D W Sep

What is the reason for your visit: _____

Medical History: Do you, or have you had any of the following?

	Yes	No		Yes	No
Rheumatic Fever/Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Eye Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Skin Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Skin Sensitivity to Adhesive Tape	<input type="checkbox"/>	<input type="checkbox"/>	Large Scars or Keloids	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	PE (Pulmonary Embolism)	<input type="checkbox"/>	<input type="checkbox"/>
DVT (Deep vein thrombosis)	<input type="checkbox"/>	<input type="checkbox"/>	Any Other Serious Illness	<input type="checkbox"/>	<input type="checkbox"/>

Have you or an immediate family member ever been diagnosed with a STAPH (MRSA) infection? Yes No

Have you ever had psychiatric problems/been under the care of a psychiatrist?

If you answered yes to any question, please explain: _____

Hospitalizations and/or Previous Surgery: Please list with dates: _____

Allergies: Are you allergic to any medications? Yes No If yes, please list medication(s) and type of reaction(s) _____

Have you or a family member ever had a bad reaction to general or local anesthesia? Yes No
If yes, please describe: _____

Medications: Please list all medications you are currently taking, including herbal medicines, diet pills, vitamins and over-the-counter medications. _____

Family History: check (X) if blood relatives have had any of the following.:

	Relationship to you	
<input type="checkbox"/> Breast cancer	_____	
<input type="checkbox"/> Skin cancer	_____	type of skin cancer if known _____
<input type="checkbox"/> Other skin diseases	_____	type if known _____
<input type="checkbox"/> Keloid scars	_____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Bleeding disorders	_____	<input type="checkbox"/> Heart disease/stroke _____
<input type="checkbox"/> Prolonged Bleeding	_____	<input type="checkbox"/> Other _____
<input type="checkbox"/> DVT (Deep vein thrombosis)	_____	<input type="checkbox"/> PE (Pulmonary Embolism) _____

Health Habits: Do you smoke: No Yes _____ per day

Work Status: Are you currently working? YES NO RETIRED Occupation: _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for errors or omissions that I may have made in completion of this form.

Signature _____

Date _____

Reviewed by _____

Date _____