HISTORY & PHYSICAL EXAM & PATIENT INFORMATION (Page 1 of 7)

Name: _____
Age: _____ Birth Date:__- __-_____
Sex: M F Marital Status: S M W D
Do you need Spanish translation or TTY service? Y N
Spouse's Name:
_____
Address: _____
City:_____ State_____
Zip:_____
Home/Best phone#: _____
Wk #: _____
Cell #: _____
Email:
_____
Care to receive email special offers? Yes / NO

Driver's License #: _____
Social Security #: _____
Occupation: _____
Employer: _____
Work Address:
_____
_____
Nearest Relative/Friend:
_____
Phone:
_____
Person Financially Responsible:
Patient _____ Parent: _____ Other: _____

If Parent or Other, please complete the following:
Name: _____
Age: _____ Relationship: _____
Address:
_____
_____
Phone #:_____
Social Security #: _____

INSURANCE INFORMATION:

Primary Insurance: _____
Policy #: _____ Group #: _____
Name of Subscriber:
_____
Subscriber Date of Birth:
_____
Relationship to Patient:
_____
Secondary Insurance:
_____
Policy #: _____ Group #: _____
Name of Subscriber:
_____
Relationship to Patient:
_____
Subscriber Date of Birth:
_____
Social Security #:_____
If subscriber is other than the patient:
Employer: _____
Employer's Phone #:
_____
Address:
_____
_____

REASON FOR CONSULTATION:

_____
_____
How did you hear about Dr. Benjamin Cousins MD?_____

I hereby authorize payment be made directly to my physician (s) or suppliers for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Patient's Signature:

_____
Date: _____

Parent or Guardian's Signature:

_____
Date: _____

Please answer the following questions to the best of your ability. Your answers are for our records only and will be considered confidential.

Name: _____ Age: _____ Sex: M F
Height: _____ Weight: _____ BMI: _____
Medical problems: _____
_____

Prior operations:
1. _____ Date: _____
2. _____ Date: _____

Name of physician: _____ Phone #: _____
Address of physician: _____

1. Are you in good health? ..... YES / NO
2. Any changes in your health in the past year? ..... YES / NO
3. Have you had rheumatic heart disease? ..... YES / NO
4. Damaged heart valves, artificial valve or heart murmur? ..... YES / NO
5. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis? ..... YES / NO
6. Chest pain or shortness of breath with mild exertion? ..... YES / NO
7. Diabetes? ..... YES / NO
8. Lung disease, asthma, bronchitis, emphysema? ..... YES / NO
9. Tuberculosis? ..... YES / NO
10. Fainting spells or seizures? ..... YES / NO
11. Liver disease, hepatitis, jaundice? ..... YES / NO
12. Thyroid problems? ..... YES / NO
13. Stomach ulcer or hyperacidity? ..... YES / NO
14. Seizures, stroke, fainting spells? ..... YES / NO
15. Kidney problems, stones, urinary tract infections? ..... YES / NO
16. HIV/AIDS, blood disorders, anemia, abnormal bleeding, blood transfusions? ..... YES / NO
17. Persistent swollen neck glands? ..... YES / NO
18. Have you ever been treated for a growth of tumor? ..... YES / NO
19. Any history of cancer? ..... YES / NO
20. Do you drink alcohol on a regular basis? ..... YES / NO
21. Do you smoke? ..... YES / NO

If you were a smoker at one time, when did you quit? _____

WOMEN:
1. How many: Pregnancies: _____ Births: _____ C-sections: _____ Miscarriages: _____
2. Are you pregnant or trying to become pregnant? ..... YES / NO
3. Do you have problems associated with your menstrual period? ..... YES / NO
4. Are you nursing? ..... YES / NO
5. Are you taking birth control pills? ..... YES / NO

ALLERGIES & CURRENT MEDICATIONS (Page 3 of 7)

Do you have any allergies? ……....YES / NO
If you are allergic, please list Medications that you are allergic to:

Type of Reaction (To)	Medication

Have you ever taken weight reduction (diet) pills? ……..YES / NO
Do you take medications for osteoporosis (bisphosphonates) such as Fosamax? ..……..YES / NO
If so, which ones? _____
Please list any medications that you currently take including vitamins and over the counter medications:

Medication	Dose	Frequency

Are there any other medical issues not covered by this form? ……....YES / NO
Do you wish to speak to the doctor privately about anything? ……..YES / NO

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's signature: _____ Date: _____

FOR COMPLETION BY THE DOCTOR

Comments on medical history:

Physician's Signature: _____ Date: _____

WHAT IS YOUR DEIRED AREA OF TREATMENT?

Facial Procedures:

- € Blephroplasty (Eyelid Lift)
- € Botox/Juvederm
- € Brow or Forehead Lift
- € Fat Injection
- € Facial Liposuction
- € Face or Neck Lift
- € Otoplasty (Ear Pinning)
- € Skin Resurfacing, Laser, etc.
- € Rhinoplasty
- € Torn Earlobe Repair

Breast Procedures:

- € Breast Augmentation
- € Breast Reconstruction
- € Breast Reduction
- € Mastopexy (Breast Lift)
- € Nipple Reduction/Inversion Correction

Body Procedures:

- € Abdominoplasty (Tummy Tuck)
- € Brachioplasty (Arm Lift)
- € Full Body Lift
- € Liposuction

Orthopedic/Hand Surgery:

- € Carpal Tunnel Syndrome
- € Trigger Finger
- € De Quervain's
- € Dupuytren's
- € Ganglion Cyst
- € Tendon Injury
- € Elbow/Finger/Wrist/Hand Fractures

Other Procedures

- € Skin Care
- € Lesions/Moles
- € Telangectasia (Spider Veins)
- € Laser Hair Removal
- € Leg Veins
- € Rosacea
- € Hair Restoration
- € Ear Piercing

Benjamin Cousins, MD -

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have reviewed/received a copy of
Patient Name

Notice of Privacy Practices

_____ _____
Signature of Patient/Guardian Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date _____ Initials: _____ Reason: _____

Formulario Para La Confirmacion Por Escrito
De Haber Recibido Aviso De Las Practicas De Privacidad..

Yo, _____, he revisado/recibido una copia del Aviso
Nombre del paciente
De las Practicas de Privacidad

_____ _____
Firma Del Paciente Fecha

OFFICE USE ONLY

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Date _____ Initials: _____ Reason: _____

HIPAA

PATIENT CONSENT & FINANCIAL AGREEMENT FORM

In connection with the medical services that I am receiving, I hereby authorize the release of my information and medical records, including copies of applicable hospital and medical records to:

A. Any third party payer covering the medical services of the patient
B. Other health care professional and institutions involved in the delivery of health care to the patient
C. The proponent of any legally sufficient subpoena, or in response to a court order
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of healthcare services and payment for such services
E. Pharmacies
F. As otherwise required by law

I further consent that photographs may be taken of me or part of my body, under the following conditions:

A. The photographs may be taken only with consent of my physician and under such conditions and at such time as approved by him/her.
B. The photographs shall be taken by my physician or by a designated person approved by my physician
C. The photographs shall be used for medical records and if in the opinion of my physician, medical research, education or science will benefit from their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other in the interest of medical education, knowledge, or research; provided, however that it is specifically understood that in any such publications or use I shall not be identified by name and reasonable steps are taken to preserve my identity.
D. The aforementioned photographs may be modified or retouched in any way that my physician, in his or her direction may consider desirable.

Regarding Financial Arrangements:

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must however realize that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for the assistance in the management of your account.

All Patients Must Sign Below:

Patient's/guardian's signature: _____ Date: _____

Print name of patient or guardian: _____

Witness/Translator: _____