## *Patient Information*

Please present health insurance card and co-payment to front desk when applicable. Thank-you.

**PATIENT Information:** (**PLEASE PRINT**) Today's Date: _____/_____/_____

First Name M.I. Last

Address City State Zip

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

E-Mail Language Ethnicity

Soc. Sec. # Birth Date Gender: □ Female □ Male

Employment Status Occupation

Employer/School Name Address

**Marital Status**: □ Single □ Married, Spouse's Name _____ □ Other _____
PLEASE SPECIFY

**Race**: □ African-American □ Asian □ Caucasian □ Hispanic □ Other _____
PLEASE SPECIFY

**Preferred Contact:** □ Home # □ Cell/Mobile # □ Work # □ E-Mail □ Other _____
PLEASE SPECIFY

**PRIMARY CARE Physician:** _____
(DOCTORS NAME) (ADDRESS) (PHONE)

**YOUR Pharmacy:**
(NAME OF PHARMACY) (ADDRESS) (PHONE)

**Incase of an EMERGENCY notify?**

Full Name Phone ( ) Relation

**REFERRED BY?** □ Our Patient _____ □ Friend/relative _____ □ Self/other _____
(NAME) (NAME)

**How did you hear about us?** □ Our Website □ Phone Book □ Facebook □ Attorney □ Staff Member _____
(NAME)

□ Physician's Office □ Health Insurance □ ASPS Website □ Internet/on-line □ Lowell General Hospital □ Other _____
(EXPLAIN)

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

First Name M.I. Last

Address City State Zip

Home Phone ( ) Work Phone ( ) Relation to Patient

**INSURANCE NAME**: Relation to Patient □ self □ parent □ spouse □ other

Insured's Full Name Birth Date Gender □ Female □ Male

Policy/ID No. Employer Name/Address

**INSURANCE NAME** (Secondary)**:** Relation to Patient □ self □ parent □ spouse □ other

Insured's Full Name Birth Date Gender □ Female □ Male

Policy/ID No. Employer Name/Address

*Continue to back page…*

**Dina Eliopoulos, MD**
Center for Plastic Surgery
9 North Road, Suite 202, Chelmsford, MA 01824

# Practice Policies/Consents

## 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 (**PLEASE PRINT**) _____ 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, including photos required to process insurance claims and/or prior authorization for surgery. 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.
- A $25.00 service fee plus any bank fees will be charged due to insufficient funds on all returned checks. In the event of a returned check final payment will be due immediately.
- Collection Agency fees will be applied to any outstanding balances owed.
- 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.

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 of requesting prior authorization for health insurance coverage, or for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc. ***By signing here, this does not give us permission to use your pictures for our website, any marketing, or for our before and after books. A separate consent would be requested in the future for these purposes.**

Patient /Parent/Guardian Signature _____ Date _____

**Dina Eliopoulos, MD**

*Center for Plastic Surgery*
*9 North Road, Suite 202, Chelmsford, MA 01824*
*Tel: (978) 275-9440 - Fax: (978) 275-9470*

**History & Physical**

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

**Reason for this visit**: _____

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

**Have you ever had the following?**

| | Yes | | Yes | | Yes | | Yes |
|---|---|---|---|---|---|---|---|
| Heart disease | | Sleep apnea | | Urinary tract infection | | Eczema | |
| Cong. heart failure | | Tuberculosis | | GERD | | Hives | |
| Chest pain/tightness | | Liver disease | | Intestinal disorder | | History of Accutane | |
| Heart murmur | | Hepatitis | | Hernia(s) | | Keloid / thickened scars | |
| High blood pressure | | AIDS or HIV+ | | GYN problems | | X-Ray Therapy/ Radiation | |
| Pacemaker | | Abnormal bleeding | | Thyroid disorder | | Psychiatric disorder | |
| Stroke | | Abnormal blood clotting | | Neurological disorder | | Depression | |
| Rapid heart beat | | Blood clot/DVT | | Seizures | | Anxiety | |
| Varicose veins | | Blood transfusion | | Breast problems | | Dry eyes | |
| Swollen feet/ankles | | Anemia | | Breast cancer | | Glaucoma | |
| Lung disease | | Autoimmune disease | | Cancer | | Hearing loss | |
| Shortness of breath when walking | | Diabetes | | Skin cancer | | Anesthesia problems | |
| Asthma | | Acute infections | | Skin disease | | Additional | |
| Chronic cough | | Kidney disease | | MRSA (Methicillin Resistant Staph Infection) | | | |

**Have you ever had a cold sore?** Yes_____ No_____

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

Have you ever had a bad reaction to local anesthetic, Novocain, or Epinephrine etc. such as heart racing, feeling jittery, etc?
Yes_____ No _____ Details _____

**Previous Surgery/Operations/Hospitalizations** (Please list below)

Operation/Hospitalization Year Hospital City Anesthesia (local/general) Surgeon's Name Complications

_____

_____

_____

_____

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

_____

Are you sensitive to adhesive tape/suture material? Yes_____ No_____

**Medications/Drugs:**

List all **medications** you are now taking and their **dosage(s)** including non-prescription drugs, vitamins and herbals, etc.:

_____

_____

_____

Continue…

**Has any blood relative had:**

| | Yes | Afflicted Family Member | | Yes | Afflicted Family Member |
|---|---|---|---|---|---|
| No contributing family history | | | Hemophilia | | |
| Adopted | | | Kidney disease | | |
| Abnormal bleeding | | | Liver disease | | |
| Von Willebrand | | | Lung disease | | |
| Abnormal clotting/DVT | | | Lung cancer | | |
| Anesthesia problems | | | Breast cancer | | |
| Malignant hyperthermia | | | Brain tumor | | |
| Autoimmune disorders | | | Melanoma | | |
| Blood or bleeding disorder | | | Ovarian cancer | | |
| Blood clotting disorder | | | Prostate cancer | | |
| Endocrine disease | | | Skin cancer | | |
| Heart disease | | | Other cancer | | |
| High blood pressure | | | Skin disease | | |
| Diabetes | | | Additional | | |
| Stroke | | | | | |

**Alcohol use: Please check which applies to you**
None_____ Socially_____ Daily_____ History of alcoholism_____
How many drinks per week? _____

**Smoking Status:**
Do you smoke? Yes_____ No_____
How many packs or cigarettes per day?_____
If former smoker, date quit? _____

**Illegal Drug Use:**
Yes____ No____ Type of illegal drug:_____
How often? _____
Indicate if drugs or alcohol ever posed a dependency problem for you: _____

**High Risk Factors:** Admits_____ Denies_____

**STD History:** Admits_____ Denies_____

**Social History:**
Your Occupation: _____
What is your marital status?_____
How many children do you have?_____
What are the ages of your children?_____
Who do you live with?_____
Support system?_____

**Exercise:**
Do you exercise?_____
If yes, what type of exercise?_____
How many times per week?_____

**Ability to Heal:**
Is your skin fragile, sensitive or burns easily? Yes___ No___
Do you form thick or raised scar from a cut or burn? Yes___ No___
Are you a slow or poor healer? Yes___ No___

**Women Only:**
Do you have regular periods? Yes_____ No_____ N/A_____
Do you take birth control pills or hormone replacement? Yes_____ No_____
Are you going through menopause? Yes_____ No_____
Are you post-menopausal? Yes_____ No_____
Are you pregnant or lactating? Yes____ No____
Breast lump or discharge? Yes____ No ____
During pregnancy, did you ever get hyperpigmentation or masking? Yes____ No____
Date of last Mammogram: _____ Results of mammogram: Normal_____ Abnormal_____
Number of pregnancies: _____ Did you breast feed? Yes_____ No_____

**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)