

L. Dwight Baker, M.D.

PATIENT INFORMATION

FIRST NAME: _____ MI: _____ LAST NAME: _____ AGE: _____

ADDRESS: _____ HOME PHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____ CELL #: _____

MARITAL STATUS: M S D W DATE OF BIRTH: _____ SS#: _____ SEX: M F

EMPLOYER NAME & ADDRESS: _____

WORK PHONE: _____ NOTIFY IN CASE OF EMERGENCY: _____

PHONE NUMBER: _____ RELATIONSHIP TO ABOVE: _____

EMAIL ADDRESS: _____

GUARANTOR INFORMATION:

FIRST NAME: _____ LAST NAME: _____

ADDRESS: _____ HOME PHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____ SEX: M F

MARITAL STATUS: M S W D DATE OF BIRTH: _____ SS#: _____

EMPLOYER NAME & ADDRESS: _____

WORK PHONE: _____

SPOUSE INFORMATION:

SPOUSE NAME: _____ SS# _____

EMPLOYER NAME & ADDRESS: _____

WORK PHONE: _____

INSURANCE INFORMATION:

WERE YOU INJURED ON THE JOB? YES _____ NO _____ DATE OF INJURY: _____

INSURANCE COMPANY:

PRIMARY: _____ POLICYHOLDER: _____

GROUP #: _____ POLICY #: _____

SECONDARY: _____ POLICYHOLDER: _____

GROUP: _____ POLICY: _____

MEDICAL INFORMATION RELEASE CONTRACT AND PROMISSORY NOTE:

I hereby authorize the release of medical information to my insurance company or their agent. I authorize my insurance company, attorney, or other agent acting on my behalf to pay directly to L. Dwight Baker, M.D., P.C. any benefits due as a result of treatment by any agent of the aforementioned corporation. We understand, that for services rendered or to be rendered, the undersigned promise to pay to the order of L. Dwight Baker, M.D., P.C. the total charges as deemed necessary and reasonable by him or his agent. There will be a 12% (twelve percent) annual finance charge compounded monthly on all unpaid balances. The undersigned may prepay this note without penalty. In the event any payment due hereunder is not paid when due, the entire balance shall be immediately due upon demand of any holder. Upon default, the undersigned shall pay all reasonable attorney fees and costs necessary for the collection of this note. Furthermore, the undersigned agree to waive all rights of exemption under Alabama state law.

SIGNATURE OF PATIENT OR GUARANTOR: _____ DATE: _____

L. Dwight Baker, M.D.

HOW DID YOU HEAR ABOUT DR. BAKER?

PHYSICIAN _____

PATIENT _____

WEBSITE: (PLEASE CIRCLE ALL THAT APPLY)

Dothanplasticsurgery.com

Implantinfo.com

Implantforum.com

iEnhance.com

lookingyourbest.com

ASPS Website (plasticsurgery.org)

ASAPS (surgery.org)

Other website _____

RADIO _____

OTHER _____

L. Dwight Baker M.D., P.C.
Dothan Plastic Surgery
105 Professional Lane
Dothan, AL 36303

PATIENT ACKNOWLEDGEMENT & CONSENT FORM

Patient Acknowledgement of Understanding of Dothan Plastic Surgery's Privacy Practices & Consent for Use/Disclosure of Health Care Information

Patient's Name: _____ Date of Birth: _____

SSN: _____ Previous Name: _____

I understand that the patient's health information is private and confidential. I understand that Dothan Plastic Surgery works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Dothan Plastic Surgery may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it.

I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Dothan Plastic Surgery has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgment. I understand that I have the right to read the "Notice" before signing this acknowledgement.

Dothan Plastic Surgery may update this Acknowledgement and "Notice of Privacy Practices". If I ask, Dothan Plastic Surgery will provide me with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

Dothan Plastic Surgery has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgements, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Dothan Plastic Surgery by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Dothan Plastic Surgery's "Notice of Privacy Practices". My signature means that I agree to allow Dothan Plastic Surgery to use and disclose the patient's personal health information to carry out treatment, payment, and health care operations.

Signature

Date

Time

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

PERSONAL HISTORY QUESTIONNAIRE

This information is confidential and will not be released without you authorization.

Name _____ DOB _____ Age _____

 Last First Middle
Ht _____ Wt _____ Sex: M F Marital Status: Single Married Widowed Divorced

Date of last physical exam _____ Doctor _____ Referring Doctor _____

Phone _____ Purpose of this consultation _____

PAST MEDICAL HISTORY: Do you or have you had? (If yes, give date of occurrence.)

AIDS or HIV	N Y _____	Bleeding tendencies	N Y _____	Asthma	N Y _____
Thyroid	N Y _____	Blood pressure	N Y _____	Lupus	N Y _____
Heart	N Y _____	Fibromyalgia	N Y _____	Cancer	N Y _____
Kidneys	N Y _____	Nervous problems	N Y _____	Lungs	N Y _____
Gallbladder	N Y _____	Bleeding problems	N Y _____	Arthritis	N Y _____
Stomach	N Y _____	Scleroderma	N Y _____	Diabetes	N Y _____
MRSA	N Y _____	Hepatitis	N Y _____	Chronic Infections	N Y _____

Do you currently smoke or use any type of tobacco? N Y If yes how much per day? _____

Have you previously smoked or used tobacco of any type? N Y If yes when did you stop? _____

Do you regularly drink over 3 cups of coffee per day? N Y

Do you regularly drink alcohol or beer? N Y How much per week? _____

Are you currently at a stable weight? N Y If yes how long have you been at this weight? _____

Are you currently losing/gaining (circle one) weight? N Y If yes how much have you lost/gained _____

Have you previously lost/gained (circle one) weight? N Y If yes how much? _____

Have you ever had Gastric-Bypass surgery or any weight loss surgery? N Y If yes when? _____

MEDICATIONS:

Are you presently taking any of the following? (Circle and list name of medication where indicated by _____)

Aspirin/Anacin	Cough medicine _____	Antibiotics _____	Phenobarbital	Dilantin
Bufferin	Thyroid pills _____	Blood pressure pills _____	Birth Control	Iron
Motrin	Hormones _____	Insulin/diabetic pills _____	Digitalis	Sleeping pills
Ibuprofen	Blood thinners _____	Arthritis medication _____	Cortisone	Water pills

Other medication not listed _____

Do you take herbal supplements? Y N If yes, what are they? _____

Do you drink or ingest Green Tea in any form (tea, tablets, soft drink, Other)? Y N Please list _____

Aspirin and aspirin type products can cause excessive bleeding during surgery.

DRUGS OR SUBSTANCES TO WHICH YOU ARE ALLERGIC _____

Do you have a Latex sensitivity or allergy? _____

FAMILY HISTORY: Have blood relatives had? (Please circle and give reason.)

High blood pressure _____	Arthritis _____	Asthma _____
Diabetes _____	Stroke _____	Goiter _____
Bleeding disorders _____	Breast cancer _____	Other cancer _____

SERIOUS ILLNESS OR INJURIES: Please list any serious illness or injuries and dates.

Illness/Injury _____ Year _____

Illness/Injury _____ Year _____

Illness/Injury _____ Year _____

OPERATIONS: Please list operations and year.

Operation _____ Year _____

Operation _____ Year _____

Operation _____ Year _____

WOMEN ONLY

Is there a chance you may be pregnant? Y N Regular menses? Y N Date of Last menstrual period _____

Any complications with pregnancy? _____

How many pregnancies? _____ How many children? _____ Did you breastfeed? Y N How many? _____

Date of last mammogram _____ Normal Abnormal

Specify abnormality _____

Breast cancer: L R Date _____ Mastectomy _____ Date _____

Breast biopsy: L R Date _____ Oncologist _____ Date _____

Surgeon for breast biopsy _____ Address _____

I acknowledge the above information is factual and this form has been completed to the best of my knowledge and ability.

Patient Signature _____ **Date** _____