MEDICAL HISTORY

Please answer all of the following questions prior to your first examination. It will help your physician to know not only about your health but also about your family.

TODAY'S DATE: _____

NAME _____ ADDRESS _____

PHONE _____ SEX _____ DATE OF BIRTH _____ AGE _____ MARITAL STATUS _____

EDUCATION _____ OCCUPATION _____ HOW LONG _____ EMPLOYER _____

DO YOU SMOKE? ____ HOW LONG? ____ HOW MANY PACKS/WK? ____ USE ALCOHOL? ____ HOW MUCH? _____

FAMILY HISTORY:

	Alive	(Present Health Condition)	Deceased	(Cause of Death)
Father				
Mother				
Spouse				
	# Alive	(Any health problems)	# Deceased	(Cause of Death)
Brothers				
Sisters				
	# Alive	(Ages & any health problems)	# Deceased	(Cause of Death)
Children				

Check illnesses which have occurred in your blood relatives: ____ Diabetes ____ Cancer ____ Bleeding Problems ____ Migraine ____ Suicide ____ High Blood Pressure ____ Heart Problems

PERSONAL HISTORY:

Family Doctor _____ Referring Doctor _____

Date of last physical _____ Any abnormal findings? _____

CHECK if immunized for: ____ Small Pox ____ Tetanus ____ Polio ____ Typhoid _____ Other

Operations (Type, Date, Hospital, Surgeon)

_____

_____

_____

_____

OTHER HOSPITAL ADMISSIONS BESIDES SURGERY (List problem, dates, hospital, admitting doctor)

_____

_____

_____

LIST ALL ALLERGIES (to medications, foods, etc.) _____

What medication are you now taking? _____

MENSTRUATION: Date of last period _____ Onset at age _____ Regular? _____ # of Miscarriages _____

Are you on Birth Control Pills? _____

WEIGHT: _____ HEIGHT: _____

What is the main reason for your visit today? _____

Circle all the things that are bothering you now or within the past year:

General: Fever, chills, soaking sweats, lumps

Eyes: Eye pain, vision loss, spots or floaters, infections, injury, glaucoma, cataracts
Date of last eye exam: _____

ENT: Dizziness, hearing loss, ringing, ear pain, infections, sinus headaches, nasal drainage, nosebleeds, mouth bleeds, sores, voice change, difficulty swallowing

Heart: Chest pain, palpitations, irregular pulse, high blood pressure

Lungs: Cough, dark sputum, bloody sputum, shortness of breath, wheezing, need high pillows, awaken at night choking, asthma, bronchitis or pneumonia

Digestive: Chronic indigestion, frequent nausea/vomiting, changes in bowel habits, diarrhea, constipation
Last hemoccult exam (if over 50): _____

Urinary: Burning urine, bloody urine, infection, VD, difficulty in starting stream, dribbling,
Get up to urinate_____ time(s) a night.

Muscular/Skeletal: Stiff / swollen / painful joints, weakness, bad back, varicose veins, muscle pain, history of fractures, muscle cramping, limitations on walking

Neuro: Nervousness, paralysis, numbness, fainting, stroke, tensions, tingling, weakness, tremors or paralysis

Blood: Anemia, bleeding tendencies, easy bruising, fatigue

Glands: Thyroid disorder, diabetes, unexplained changes in height or weight, previous or current hormone therapy, hair change, skin changes, heat/cold intolerance, loss of sex drive

Psych: Depression, anxiety, stress-related problems

Allergic/Immune: Eczema, hives and/or itching, frequent sneezing, chronic clear nasal discharge, conjunctivitis, any allergy that causes interference with activities of daily living

Skin & Breast: Sores, color changes of lesions, breast pain / tenderness / swelling, history of nipple discharge / changes
Date of last mammogram: ____ / ____ / ____

Comments: _____ Dr. _____
(Date)

Comments: _____ Dr. _____
(Date)

Comments: _____ Dr. _____
(Date)

Comments: _____ Dr. _____
(Date)

Date: _____

PATIENT INFORMATION:

Title: (Mr., Mrs., Ms.) First Name: _____ Middle Initial: _____ Last Name: _____

Sex: ____ Male ____ Female Date of Birth ____ - ____ - ____ Age: ____ Social Security No.: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Tel.: ( ) _____ Bus. Tel.: ( ) _____ Cell Tel.: ( ) _____

Email: _____

Physician: _____ Address: _____

Whom may we thank for referring you to us?: _____

Who will be responsible for your account? Relation: ❑ Self ❑ Spouse ❑ Mother ❑ Father ❑ _____

Name: _____ Soc. Sec. #: _____ Home Tel.: ( ) _____

Street: _____ City: _____ State: _____ Zip: _____

Employer: _____ Tel.: ( ) _____

❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single ❑ Spouse's Name: _____

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not Spouse's Employer: _____

Ethnicity: ❑ Caucasian ❑ African American ❑ Native American ❑ Asian ❑ Other _____

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INSURANCE COMPANY:	**INSURED PARTY:**
Name: _____	Name: _____
Address: _____	Relation to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other
_____	Sex: ❑ M ❑ F Date of Birth: _____
Phone ( ) _____	Street _____
_____	City, State, Zip: _____
Group No.: _____	Phone ( ) _____
Group Name: _____	S.S. No.: _____ ID No.: _____

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INSURANCE COMPANY:	**INSURED PARTY:**
Name: _____	Name: _____
Address: _____	Relation to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other
_____	Sex: ❑ M ❑ F Date of Birth: _____
Phone ( ) _____	Street _____
_____	City, State, Zip: _____
Group No.: _____	Phone ( ) _____
Group Name: _____	S.S. No.: _____ ID No.: _____

INSURANCE COMPANY: **INSURED PARTY:**

Including yourself, and your physician, who else would you like us to release your confidential medical information to (if they request it)?

Name: _____ _____

_____ Signature: _____

Friend or Relative (other than spouse) to leave message with in case of emergency:

NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE

FEES AND PAYMENTS:

We make every effort to keep down the cost of your plastic and reconstructive surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have medical insurance, we will be glad to file your claim for you.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibililty to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.

The clinic expects payment of accounts within 30 days following the date they were billed. A FINANCE CHARGE is computed on account balances unpaid 60 days after the first billing at PERIODIC RATE OF 1.25% PER MONTH (ANNUAL PERCENTAGE RATE OF 15%). If all attempts to collect payments due the clinic fail, the patient or guarantor will be responsible for attorney fees and costs that are incurred for the collection of the debt.

Please be informed: The Physicians of Sioux Falls Center for Plastic and Reconstructive Surgery have an ownership interest in the Sioux Falls Specialty Hospital.

AUTHORIZATION AND ASSIGNMENT:

This signature on file is my authorization for the release of information necessary to process my claim and/or secure payment. I hereby authorize payment directly to Dr. Richard J. Howard or Dr. Thomas C. Howard of the insurance benefits otherwise payable to me. This assignment will remain in effect until removed by me in writing.

HIPAA Notice of Privacy Practices

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to suppose the operation of the physician's practice, and any other use required by law. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. Your protected health information will be used, as needed, to obtain payment for your health care services. Other permitted and required uses and disclosures will be made only with your content, authorization or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. You have the right to inspect and copy your protected health information. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically. You may have the right to have your physician amend your protected health information. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

We are required by law to maintain the privacy of, and provide individuals with the notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

☐ I hereby acknowledge and agree to all above statements.

Print Name	/ Signature of Patient or Responsible Party	/ Date