

PATIENT INFORMATION

Patient
Full Name: _____ Today's Date: _____
(First) (M.I.) (Last)

Street Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____

Work Phone: _____ Cell Phone or Pager: _____

Which Number can we call regarding and appointment? Home Work Cell/Pager

E-mail Address: _____

YES ___ I want updated e-mails NO ___ I do not want any e-mails

Social Security Number: _____ Birthdate: _____

Sex: _____ Marital Status: _____ Age: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Phone Number(s): _____

How did you hear about us? _____

INSURANCE INFORMATION

WE WILL NEED A COPY OF YOUR INSURANCE CARD(S) BEFORE SERVICES
(If you are here for a cosmetic procedure your insurance card is not needed.)

Full Name of Policy Holder: _____

Relationship to patient: _____ Birthdate: _____

Same as above or Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security Number: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

**COASTAL FACIAL PLASTIC SURGERY, P.A.
HISTORICAL DATA SHEET**

Name: _____ Date of Birth: _____

Home Address: _____

Work Address: _____

Telephone: _____ Work: _____ Cell: _____

May we contact you by phone? _____ Marital Status: S M D Sep

Occupation: _____ Age of Children: _____

How were you referred to us? (Check all that apply and fill in name of doctor or person)

- | | |
|----------------------------|---------------------------------------|
| _____ Friend _____ | _____ Yellow Pages _____ |
| _____ Patient _____ | _____ Magazine _____ |
| _____ Doctor _____ | _____ Newspaper _____ |
| _____ Dentist _____ | _____ Other Media _____ |
| _____ Nurse _____ | _____ Hospital Referral Service _____ |
| _____ Insurance comp _____ | _____ Other _____ |

Which procedure(s) are you interested in?

- | | | |
|--------------------------|---------------------|--|
| _____ Rhinoplasty (nose) | _____ Chin | _____ Collagen |
| _____ Eyelids | _____ Chemical Peel | _____ Fat transfer |
| _____ Face or neck lift | _____ Dermabrasion | _____ Hair transplant |
| _____ Forehead lift | _____ Parisian Peel | _____ Removal of cyst/mole/skin cancer |
| _____ Ears | _____ Botox | _____ Scar Revision |
| | | _____ Other |

Have you consulted another doctor in regards to this type of procedure(s)? Yes No

If so, whom? _____

Have you had any previous cosmetic surgery? Yes No

If yes, please state what type of procedure and when performed: _____

Who performed the surgery? _____ Were you satisfied with results? Yes No

If no, why? _____

MEDICAL HISTORY

When was your last physical examination? _____

Who is your family doctor? _____

Who is your internist? _____

Who is your OB/GYN? _____

No Yes List allergies to any medication: _____

No Yes Have you had any reaction to Local or any other anesthesia?
Explain: _____

No Yes Are you taking any over the counter or prescription medication? List them.

No Yes Do you take vitamins regularly? _____

No Yes Are you pregnant at present or trying to conceive?
When was your last menstrual period? _____

No Yes Have you ever taken acutane?

No Yes Do you take aspirin, Advil, Motrin, or any other medicines that may affect clotting or bleeding?

No Yes Have you ever had herpes, fever blisters, or cold sores? Circle those which apply.

No Yes Have you ever had surgery or injuries to or around the face, neck or eyes?
If so, when? _____ Describe injury: _____

No Yes Do you have a history of bleeding or excessive bruising?

Have you or any member of your immediate family been affected by any of the following conditions? Please identify who by relationship.

_____ Heart trouble _____	_____ Bleeding _____
_____ High Blood Pressure _____	_____ Poor healing _____
_____ Diabetes _____	_____ Psychiatric or nerve problems _____
_____ Thyroid Condition _____	_____ Excessive scarring _____
_____ Arthritis _____	_____ Tuberculosis _____
_____ Excessive bruising _____	_____ Other _____

Have you ever had any of the following surgeries? (Give dates)

_____ Sinus surgery _____	_____ Skin surgery _____
_____ Tonsillectomy _____	_____ Skin surgery _____
_____ Adenoidectomy _____	_____ Skin surgery _____
_____ Chest or Lung _____	_____ Skin surgery _____
_____ Bladder surgery _____	_____ Skin surgery _____
_____ Fracture repair _____	_____ Skin surgery _____
_____ Hernia repair _____	_____ Skin surgery _____
_____ Reproductive system including D&C, removal of ovary, hysterectomy, or C-Section _____	

Number of pregnancies: _____ Number of deliveries: _____

Were there any complications to any of the above mentioned procedures? _____

No Yes Do you have hay fever, asthma, or allergies?

No	Yes	Do you have chest pains with stress or exertion?	
No	Yes	Do you have stomach trouble or ulcers?	
No	Yes	Have you ever had liver, gall bladder trouble, or yellow jaundice? (circle which)	
No	Yes	Do you have skin irritations, rashes or sensitivity to adhesive tape?	
No	Yes	Do you have headaches or dizzy spells?	
No	Yes	Has any part of your body been paralyzed?	
No	Yes	Do you ever have convulsions or seizures?	
No	Yes	Have you ever had loss of vision?	
No	Yes	Do you have dry or teary eyes?	
No	Yes	Do you suffer with blurred vision?	
No	Yes	Are you being treated for glaucoma?	
No	Yes	Were you ever treated for anemia?	
No	Yes	Have you ever been treated for a venereal disease?	
No	Yes	Have you ever taken hormones or thyroid medicine?	
No	Yes	Do you smoke more than 10 cigarettes per day?	
No	Yes	Do you drink more than 3 cups of coffee per day?	
No	Yes	Do you usually drink two or more alcoholic beverages per day?	
No	Yes	Do you often get depressed?	
No	Yes	Have you ever had a nervous breakdown or panic attack?	
No	Yes	Have you ever received medical attention for a nervous condition?	
No	Yes	Are you fearful of doctors or dentists?	
No	Yes	Do you have any medical problems that have not been covered?	
No	Yes	Are there any private medical conditions such as drug use, HIV infection, etc that you would like to discuss privately?	
No	Yes	Do you give consent and authorize the recommended diagnostic, medical, surgical, anesthetic and other diagnostic services that the clinic deems beneficial while you are	under their
		care?	

Signature: _____ Date: _____

FINANCIAL POLICY

Dear Patient:

Welcome to our office. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments that you need. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our financial counselor.

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing Dr. Funcik.

Payment for services is due at the time services are rendered. We accept cash, check and for your convenience, MasterCard and Visa.

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Patient Signature: _____ Date: _____

INSURANCE POLICY

We will file your insurance for your reimbursement as long as we have all the correct insurance information.

In special instances, we may accept assignment of insurance benefits. We do participate with several plans including Medicare, most Blue Cross Blue Shield Plans, Tricare and several others. Please check with the front desk to find out if we participate with your specific insurance. We will file secondary as well. However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.
4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help speed things up.
5. If the insurance company does not pay in full within 45 days, we require you to pay the balance due with check, cash, MasterCard or Visa.
6. If your account has to be turned over for collection, you agree to pay all legally allowed interest and all collections and attorney fees.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

INSURANCE ASSIGNMENT

I authorize payment directly to Coastal Facial Plastic Surgery, P.A., for the medical and/or surgical services rendered. This is to include health and/or liability, "Medigap" policies, and other insurances, including auto casualty. I authorize any holder of medical information about me to release to the health care financing administration and its benefits payable for related services. In the event that my insurance company does not pay for the service(s) rendered, I accept personal responsibility for the expenses incurred and further request that this service be provided.

Patient Signature: _____ Date: _____

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Coastal Facial Plastic Surgery, P.A., for any service(s) furnished to me by that office. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits payable for related services. If determinations are made by Medicare that specific services are not covered by Medicare Policy, you agree to be responsible for payment of non-covered charges.

Patient Signature: _____ Date: _____