PERSONAL HISTORY QUESTIONNAIRE

Name:_____

REASON FOR VISIT:_____

Pharmacy:_____ **Pharmacy phone #:**_____ **Location:**_____

PAST MEDICAL HISTORY: Do you have 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_____	MRSA	N Y_____
Heart	N Y_____	Lungs	N Y_____	Cancer	N Y_____
Kidney	N Y_____	Depression	N Y_____	Fibromyalgia	N Y_____
Gallbladder	N Y_____	Anxiety	N Y_____	Blood clots	N Y_____
Arthritis	N Y_____	Stomach	N Y_____	Diabetes	N Y_____
Autoimmune	N Y_____	Hepatitis	N Y_____	Sleep Apnea	N Y_____

Other medical problems_____

Do you regularly smoke? Y N How much per day?_____
Do you regularly drink alcohol or beer? Y N How much per week?_____
Do you use recreational drugs? Y N What do you use? _____

MEDICATIONS: Are you presently taking any of the following? (Circle)

Aspirin/Aleve	Thyroid medicine	Blood pressure pills	Blood thinners	Vitamins
Motrin	Hormones	Insulin/diabetic pills	Digitalis	Sleeping pills
Ibuprofen	Birth control pills	Arthritis medicine	Steroids	Herbal supplements
Cough medicine	Antibiotics	Pain medicine	Seizure pills	Water pills

Other medications not listed_____

ALLERGIES:_____

FAMILY HISTORY: (Please circle and note which family member)

Heart disease_____	Stroke_____	Bleeding problem_____
Diabetes_____	Breast cancer_____	Other cancer_____

SERIOUS ILLNESSES OR INJURIES: (Please list and note year)

Incident_____ Year_____

Incident_____ Year_____

OPERATIONS: (Please circle and note year)

Breast surgery_____	Hand surgery_____	Hysterectomy_____
Face surgery_____	Hernia repair_____	Cholecystectomy_____
Tubal ligation_____	Colectomy_____	Heart surgery_____

Other surgeries_____

SUPPORT SYSTEM:

Do you live with anyone at home? Y N
Who can you contact to help with your recovery if needed?_____

WOMEN:

Is there a chance you may be pregnant? Y N

Any complications with pregnancies?_____ How many children?_____ Breastfeeding Y N

Have you had a mammogram Y N Date of last mammogram_____ Normal Abnormal

PATIENT INFORMATION

Patient Legal Name:_____**Middle initial:**_____ Marital status: S M W D

Preferred name:_____

Social Security # _____-_____-_____ **DOB:** _____ **Age:** _____ **Gender:** _____

Home address: _____ Zip: _____

Mailing Address (if different)_____ Zip: _____

Cell Phone: _____ May we leave a Detailed message? Y N

Home Phone: _____ May we leave a Detailed message? Y N

Work Phone: _____ May we leave a Detailed message? Y N

Email_____

Employer: _____ Employer Phone: _____

Occupation: _____Employer City & State_____

Primary doctor: _____ Phone: _____

Referred by: _____Pharmacy Location & phone #_____

Emergency Contact(s)

Name(s): _____ Phone(s): _____

Relationship(s) to Patient: _____

Is there anyone you would like us to be able to discuss your medical care with?

Name: _____ Phone: _____

Relationship to Patient: _____

Name: _____ Phone: _____

Relationship to Patient: _____

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Responsible Party/Parent/Guardian ***(Skip if info is the same as patient info)***

Person(s) responsible for bill: _____ *DOB:* _____

*Social Security #*_____-_____-_____ *Address:* _____*Zip:* _____

Employer: _____ *Occupation:* _____

Home Phone: _____ *Work Phone:* _____

Insurance Information

You are always responsible for your own medical bills. However, if another person's negligence or carelessness caused your injury and you intend to recover the amount of your medical bills from that person or his/her insurance company, please give us notice.

- Is this a ***work related injury, auto accident*** or a claim that will be processed/paid by someone else or their insurance? ***Y N***
- (If yes) Insurance name, Claim number & Adjuster info:

_____

I understand that it is *my* responsibility to **confirm with *my* insurance if a referral is in place (if needed) and that Dr. Jenq is in-network prior to being seen** and that any increase in bill due to a lack of referral/out of network will be **my responsibility.**

Our financial policy is:

- We accept self pay for uninsured patients at time of service, payable with cash, check, Visa or MasterCard and Care Credit.
- **MEDICARE.** We accept assignment on Medicare claims. If you have Medicare, you will be required to pay your 20% coinsurance and your deductible at the time of service or show proof that you have met your deductible.
- If our physician is **not** in network with your insurance company, as a courtesy, we will file your claims for you, if you assign benefits to our physician. If your insurance company does not pay within a reasonable time, you will be responsible for payment.
- If our physician **is** in network with your insurance company, we will file your claim and you will be billed for deductibles, co-payments and co-insurance DUE AT THE TIME OF SERVICE.
- To **avoid a late charge of $5.00** per billing cycle your payment must be received within 30 days of the statement date or 5 business days of the payment plan transaction date.
- A $30.00 fee will be assessed for any returned checks.
- Cancellations are required at least 24 hours prior to your appointment. There will be a **$25.00 fee assessed for no show** appointments. **After 3 no show appointments** you will be discharged from our practice.
- We offer payment plans for qualified accounts upon request.
- From time to time, as an executive decision, billing and costs may be waived to aid in the treatment of patients. Nothing in this decision or act shall be construed as an admission of negligence or substandard care but only an assistance to facilitate patient care.

_____
PRINT PATIENT NAME

_____ _____
SIGNATURE OF PATIENT OR SPOUSE OR RESPONSIBLE PARTY DATE

_____
PRINT SPOUSE OR RESPONSIBLE PARTY NAME

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PHOTOGRAPHIC CONSENT

I hereby voluntarily grant permission to The OCRC to take and use photos of myself (patient) **for purposes of treatment, monitoring progress as well as assisting others in making their surgical decisions**.
The OCRC will **NOT** post your pictures online or use them for purposes other than listed above. **In most cases pictures are used to monitor progress of healing.** Any of these uses may be eliminated from this form.
I further understand that no form of compensation shall become payable to me for the use of these photographs.
I hereby release The OCRC and its agents from any and all claims and demands arising out of or in conjunction with the use of these photographs.

_____
PRINT PATIENT NAME

_____ _____
SIGNATURE OF PATIENT OR SPOUSE OR RESPONSIBLE PARTY DATE

_____
PRINT SPOUSE OR RESPONSIBLE PARTY NAME

ACKNOWLEDGEMENT OF "NOTICE OF PRIVACY PRACTICES"

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. A copy of our "Notice of Privacy Practices" is made available at the receptionist desk. I understand that this information can and will be used to:
1. Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly;
2. Obtain payment from third party providers;
3. Conduct normal healthcare operations such as quality assessments and physician certifications.
I understand that Oregon Cosmetic and Reconstructive Clinic has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you agree than you are bound to abide by such restrictions.

_____
PRINT PATIENT NAME

_____ _____
SIGNATURE OF PATIENT OR SPOUSE OR RESPONSIBLE PARTY DATE

_____
PRINT SPOUSE OR RESPONSIBLE PARTY NAME