PATIENT INFORMATION

Name: _____ Age: _____ Home Number: _____

Address: _____ Cell Number: _____

City: _____ State: _____ Zip Code: _____

Employed by: _____ Position: _____

Work Number: _____ E-mail: _____

Marital Status: _____ Sex: _____ DOB: _____ SS#: _____

Race: ____ African-American ____ Asian ____ Caucasian ____ Hispanic ____ Other: _____

Ethnicity: _____ Language: _____

Spouse: _____ Phone Number: _____

In Case Of Emergency Contact: _____

Relationship: _____ Phone Number: _____

Pharmacy Name: _____ Phone Number: _____

Pharmacy Address: _____

Reason for seeing Doctor? _____

Who referred you to our office? _____

Primary Care Physician: _____ Phone Number: _____

INSURANCE INFORMATION:

Is this related to a Car Accident or Workers Compensation Accident _____ Yes _____ No

What is your Primary Health Insurance? _____ ID Number: _____

What is your Secondary Health Insurance? _____ ID Number: _____

□ YES □ NO Do you drink alcoholic beverages?
□ YES □ NO Do you smoke?
□ YES □ NO Have you ever used street drugs?

I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature _____ Date _____

Witness: _____ Date: _____

MEDICAL INFORMATION

- **Medical History**- Check All That Apply ☒

Breathing Problems- ☐ Emphysema ☐ Asthma ☐ COPD ☐ Bronchitis
Gastrointestinal- ☐ Ulcers/ Reflux ☐ Colitis ☐ Gall Bladder ☐ Hernia
☐ Liver Disease/Hepatitis ☐ Kidney Disease
Heart Disorder- ☐ Arrhythmia ☐ Anemia ☐ Heart Valve
☐ Heart Attack- Date _____
☐ High Blood Pressure ☐ Low Blood Pressure
☐ Coronary Artery Disease
Blood Vessels- ☐ Peripheral Vascular Disease ☐ Stroke/ TIA
Eye Problems- ☐ Vision Problems ☐ Glaucoma ☐Dry Eyes ☐ Cataracts
☐ Diabetes ☐ Thyroid Disorder ☐ Arthritis
☐ Bleeding Disorder
☐ Neurologic Disorder ☐ Headaches/ Migraines
☐ Cold Sores**/**Fever Blisters
Cancer- ☐ Skin ☐ Colon ☐ Lung ☐ Breast ☐ Prostate

Other Medical History_____
☐ YES ☐ NO Have you or any family member experienced a high temperature or muscle cramping during surgery?
☐ YES ☐ NO Have you ever been treated for a MRSA or staph infection?

- **Surgery History**- Check All That Apply ☒

Cosmetic Surgery - ☐ Face ☐ Eyes ☐ Neck ☐ Breast ☐ Abdomen
Heart/ Lung - ☐ Bypass Graft ☐ Valve Replacement ☐ Angioplasty/ Stents
☐ Lung Surgery
Blood Vessels- ☐ Leg Bypass ☐ Carotid ☐ Vein Stripping
Abdomen- ☐ Hernia ☐ Gall Bladder ☐ Colon
☐ Stomach Other- _____
GYN/GU- ☐ Hysterectomy ☐ Bladder ☐ Breast Surgery ☐Prostate
Orthopedic Surgery- ☐ Hip ☐ Knee ☐ Shoulder ☐ Back
☐ Eye Surgery/ Cataracts ☐ Other Surgery- _____

- **FAMILY HISTORY-** ☐ **None** ☐ **Melanoma** ☐ **Breast Cancer** ☐ **Heart Problems**
- **DRUG ALLERGIES/SENSITIVITIES-** ☐ **NONE** ☐ **Penicillin** ☐ **Sulfa drugs** ☐ **other drugs**

- **Medications**- **PLEASE PRINT CLEARLY**: include herbal supplements, eye drops, ointments and dosage information:

Medication Name	Dosage	Medication Name	Dosage
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Height_____ **Weight**_____ **Most Recent Blood Pressure measurement**_____

I HAVE READ THE ABOVE MEDICAL INFORMATION LISTING AND I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature _____ Date _____

Notice of Rights and Responsibilities- At Dr. Bogue's office, we are committed to treating and using protected health information about you responsibly. This notice of health information practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice applies to all protected health information as defined by federal regulations.

Each time you visit Dr. Bogue's office, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and plan for future care and treatment. This information, often referred to as your health or medical record, serves as:

- Basis for planning your care and treatment.
- Means of communications between your health care providers.
- Legal document describing the care you received.
- Means by which you or a third-party payer can verify that services billed were actually provided.

Although you health record is the physical property of Dr. Bogue, M.D., the information belong to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy your health record as provided for in 45 CRF 164.524.
- Amend you health record as provided in 45 CFR 164.528.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528.

We will use your health information for regular health operations. We will use your health information for treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you once you're discharged from this hospital.
We will use your health information for payment. *For example:* A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

I certify by signing below indicates that I have received, read and understand the following Items:

- Notice of Information Practices.
- Statement of Consumer Rights.
- Service Information, Financial Guidelines, and General Policies.

And I have had the opportunity to ask questions regarding the above, as well as, any questions regarding my registration with this center.

Photographs- Pre and postoperative photographs are essential in Plastic Surgery both for planning and for analysis of postoperative results. It is the policy of the office that all patients coming in for surgery have photographs taken. These photographs are intended solely for use in the office. They cannot be shown to any prospective patients; nor can they be used in any talks or demonstrations without the expressed permission by you, the patient. I have read the above and fully understand the implications. I hereby give my consent to allow David Bogue, M.D. to take pre operative, intra operative and/or post operative photographs of me.

Release of information/Medical records and assignment of benefits- I hereby authorize David Bogue, M.D. to release any information acquired in the course of my examination or treatment to my attorneys, physicians, and /or insurance companies or for quality assurance and peer review. I hereby grant permission for the use of any on my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by the American Board of Plastic Surgery, Inc. I hereby authorize payment directly to David Bogue, M.D. for surgical benefits and/or major medical benefits under the terms of my insurance. I understand I am financially responsible for all charges whether or not paid by my insurance. I also understand that a finance charge of 1.5% may accrue on all unpaid balances. I hereby authorize photocopies of this form to be valid as the original. This statement will remain in effect until revoked by me in writing.

Signature: _____ Date: _____

Witness: _____

Photography Consent

I, _____, consent to the taking of photographs by Dr. David Bogue or his designee of me or parts of my body in connection with the plastic surgery procedure(s) intended or performed by Dr. Bogue. I understand that photographs may be taken before, during, and after my procedure(s) as a routine part of my medical care. I further understand that these photographs will be kept strictly confidential.

Signature:_____ Date:_____

Release of Photographs Consent

Additionally, I authorize the use of my photographs in the formats listed below. I waive any right to inspect or approve the finished product, advertising, or other copy that may be used in connection with the options below. I understand that I will **never** be identified by name in any use of these photographs, but that in some circumstances the photographs may portray features which make my identity recognizable.

(Please initial YES or NO for each of the items below)

_____ YES _____ NO For our **office photo gallery** to help future patients understand and see outcomes from surgery with Dr. Bogue.

_____ YES _____ NO On our **website or affiliated websites** for prospective patients to see and understand outcomes from surgery with Dr. Bogue.

I release and discharge Dr. Bogue from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

Print Name: _____ Date: _____

Signature: _____

Witness: _____

This consent may be revoked at any time with a written consent.