CENTER FOR PLASTIC &
RECONSTRUCTIVE SURGERY
face · body · breast · skin

PLEASE COMPLETE PATIENT INFORMATION FORM. MAIL/ FAX TO OUR OFFICE **AT LEAST 5 BUSINESS DAYS PRIOR TO APPOINTMENT**.
MAILING ADDRESS: 5333 MCAULEY DRIVE SUITE 5001, YPSILANTI, MI 48197 FAX: 734.712.2312 PHONE: 734.712.2323

Physician (circle one): David Hing, M.D. Richard Beil, M.D. Daniel Sherick, M.D. Ali Charafeddine, M.D.

Patient Information: **Appointment Date:** ___________________________

Name:____ **Prefix:** □ Mr. □ Ms. □ Mrs. □ Miss □ Dr.
Last *First* *Middle Initial*

Date of birth: _____/____/______ **Sex:** □ Male □ Female **Social Security Number:** _________________________
Month Day Year

Address:____
Street *City* *State* *Zip*

Email address: ____

Phone: ____
Home *Cell* *Work*

Race: □ American Indian/Alaska Native □ Asian □ Black/African American □ Caucasian
□ Native Hawaiian/Pacific Islander □ Other Race □ Unknown □ Declined

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Declined **Religion:**_______________________

Marital status: □ Married □ Single □ Divorced □ Widowed **Primary Language:** _______________________

Preferred method of communication (check one): □ Text □ Cell Phone CALL □ Home Phone CALL □ Email

Emergency contact:____**Phone #:**________________________
Name *Relationship to patient*

Preferred pharmacy: ____
Name *Street* *City* *Zip* *Pharmacy Telephone Number*

Physician Information: Please provide the name, telephone and address for the physician(s) who provide your care:

Referring Physician:____
Last *First* *Telephone #* *Street* *City* *State* *Zip*

Primary Care Provider:____
Last *First* *Telephone #* *Street* *City* *State* *Zip*

I authorize CPRS to correspond with the physician(s) listed above concerning my condition and treatment plan.
□ Yes □ No If "no", please list the reason(s) you do not wish your doctor to correspond with your other physicians:
____

How did you learn about our practice?

□ Physician:_______________________________ □ Hospital:_________________________________
□ Another patient:__________________________ □ Friend:__________________________________
□ Website □ Seminar □ RealSelf.com □ Social Media (circle one): Facebook Instagram
□ Publication *(circle one)*: New Beauty/Ann Arbor.com /Ann Arbor Observer /Other:____________________
□ Other (i.e., Employee, Attorney, Referral Line):____

May we send you ongoing information on exclusive discounts and upcoming special events? □ **Yes** □ **No**

Insurance Information: please give your insurance cards to the receptionist for copying

Primary Insurance:______________________________ ID #:______________ Group #:________________

Secondary Insurance:____________________________ ID #:______________ Group #:________________

If your medical insurance is in someone else's name, please complete the "Insurance Subscriber" Information:

Subscriber's Name:______________________________ Relation to Patient:______________________

Last *First* *Middle Initial*

Subscribers: Date of Birth: _____/____/______ Sex: □ Male □ Female Social Security Number: ________________

Month Day Year

Subscriber's Address:____

Street *City* *State* *Zip*

Subscriber's Employer:___________________________ Subscriber's Phone #:____________________

Acknowledgement of Receipt of Notice of Privacy Practices:

I further acknowledge receiving a copy of the Center for Plastic & Reconstructive Surgery, P.C. Notice of Privacy Practices on the date below.

Name: (print)____

Signature: ____ Date:________

Patient or responsible party if patient is under age 18

Auto Insurance or Workers' Compensation Information:

□ Auto - or- □ Workers' Compensation Date of injury: _____/_____ /_______ State of injury: _____________

Claim Number: ____________________ Insurance Company Name:______________________________

Claims Billing Address:____

Street *City* *State* *Zip*

Claim Adjustor's Name: ______________________________ Phone #: ________________________

Occupation:_____________________________________ Employer: _____________________________

Employer Address: ____

Street *City* *State* *Zip*

Do you have a Durable Power of Attorney for Health Care?

□ Yes □ No If yes, please bring a copy to your appointment.

Medications: Please list all medications you are presently taking (include dosage and frequency).

If none, please check. □

Medication Name	Dosage	Frequency

When did you last take aspirin, Motrin, Advil, Aleve, ibuprofen, Alka-Seltzer or other pain medication (excluding Tylenol)?_______

____

____

Do you now take or have you recently taken any of the following? Yes / No If yes, please specify.

Anti-depressants:________________________________ Birth control pills:________________________________

Arthritis medications:____________________________ Diet pills:________________________________

Herbal products (*e.g.*, Metabolife, Appendrine, Comfrey, Garlic, Gingko, Chamomile, St. John's Wort, Kava, Sassafras, vitamins):

____

____

Allergies: If none, please check. □

Allergen	Yes	No	If yes, please specify
Penicillin			
Codeine			
Aspirin			
Local Injected Anesthetic			
Iodine on the skin			
Surgical tape			
Latex			
Other drugs/medications:			
Other Allergy:			

Surgeries and Major Hospitalizations: If none, please check. □

Date	Procedure	Reason	Place

Past Medical History:

Type of Disease/Disorder	Yes	No	Type of Disease/Disorder	Yes	No	Type of Disease/Disorder	Yes	No
Anemia			Frequent Nose Bleeds			Mitral Valve Prolapse		
Anesthesia problem/include family			Head Injury:___________			Morbid Obesity		
Arthritis			Headaches/Migraines			Multiple Sclerosis		
Asthma			Heart Attack/Pain (Angina)			Nervous Breakdown		
Auto-Immune Disease			Heart Failure			Pacemaker		
Bleed Easily			Heart Murmur or Defect			Phlebitis		
Blood Clots			Hepatitis B			Polio/Meningitis		
Blood Disorder(s)			Hepatitis C			Rheumatic Fever		
Blood Transfusion			Herpes			Scoliosis		
Bruise Easily			High Blood Pressure			Shortness of Breath		
Cancer - *type:*___________			HIV Positive/AIDS			Sleep Apnea: CPAP? Yes/No		
Caps/Dentures/Bridges			Intertrigo/Skin Irritation/Ulcer			Stroke(weakness/paralysis)		
Diabetes			Irregular Heart Beats			Tuberculosis		
Emphysema			Kidney/Bladder Disease			Ulcers of Stomach or Bowel		
Epilepsy/Seizures			Liver Disease			Other:		
Fainting Spells			Loose/Missing Teeth					

Approximate date and provider of most recent physical exam: ____

Family Medical History:

Any family illness? (Heart disease, cancer: type, diabetes, etc.)____

____

____

If parent(s) is (are) deceased, please provide age and cause of death:

Mother:____

Father:____

Social History:

Occupation:____Employer: ______________________________

Tobacco Products: □ Never □ Former □ Current; Frequency: □ Every Day □ Some days; Packs per day: ___________

Alcohol Consumption: □ Never □ Former □ Current Frequency: □ Every Day □ Some days Drinks per week:_______

Are you or could you be pregnant? Yes / No Are you □ left handed or □ right handed?

Specify religious/ethical concerns regarding surgery or blood transfusions?______________________________

____

Does your occupation or social activity place you at risk for any of the following?

Hepatitis B Yes/No *Aids* Yes/No *Tuberculosis* Yes/No

If yes, please explain: ____

Cosmetic Interest Survey:

Do you have interest in hearing about other services provided by the Center for Plastic & Reconstructive Surgery?

□ Cosmetic Surgery □ Lasers (IPL/Laser Hair Removal) □ Injectables (Botox/Filler/Kybella)

□ Skin Care (Products/Services) □ CoolSculpting Fat Reduction □ Massage

Additional comments:

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CPRS Patient Financial Responsibility & Terms of Payment Acknowledgement:

The Center for Plastic and Reconstructive Surgery ("CPRS") participates with specific insurance products from Aetna, Auto, BCBS, Blue Care Network, HAP, Medicare, Priority Health, TriCare, United Health Care, Worker's Compensation and also Medicaid with a primary care physician's referral. Please see below.

Aetna *– PPO, Select and Elect Choice. We do not par with Aetna HMO plans.*
HAP *– ASO, HMO, PPO, POS, Senior Plus, Alliance*
BCBS *– BCN, EPO, Federal, Traditional, PPO Trust, and Blue Preferred Plus.*
Priority Health *– HMO, PPO and POS.*
Medicaid *– BC Complete, HAP Midwest, Healthy Michigan Plan, Meridian, Meritain Health, Molina, Washtenaw Health Plan.*
United Health Care *– Charter, Choice, Core, Medica Choice, Options, Passport, Select (not HMO), Select Plus (not HMO) and Additional Network Benefit Plan. We do not participate with United Health Care Medicaid plans.*
Auto & Work Comp *– Must have an open claim with authorization and date of injury. We will not accept cases in dispute.*
*****This is a general list of insurances that we participate with. Please verify the participation status of your insurance plan at each visit.

You are required to know the rules and regulations of your insurance carrier and obtain any required referrals or authorizations in accordance with those rules. A referral for treatment is not a guarantee of payment, your insurance company may still deny the charges. You are responsible for the bill in its entirety should your insurance company deny payment.

All patients presenting with insurance are responsible for insurance copays, deductibles, non-insurance covered charges and services deemed to be cosmetic, per your insurance contract.

All patients presenting for cosmetic services will be expected to pay in full and no insurance claim will be filed. Payment for services can be made using: Cash, Check, Visa, MasterCard, American Express & Discover Card.

All consultations and office visits will either be billed to you or your insurance company. This practice does not offer free consultations or office visits.

If you have insurance that we do not participate with, you will be responsible for the office visit charge at the time of your visit. We may accept assignment from your insurance carrier on certain procedures. This option can be discussed with our staff.

- If we accept your insurance, your insurance claims will be filed for you through our office.
- If we agree to accept assignment from your out-of-network insurance, you must obtain an out-of-network authorization and your insurance claim will be filed for you as a courtesy. You will be responsible for all non-covered charges.
- If you present for services at this office without insurance coverage or with insurance that we do not participate with, payment in full will be expected at the time of service and no insurance claim will be filed for you.

Portal Patients: By creating a portal account, you agree to these terms. You may print a copy of this form for your records or ask for a copy from our office.

By signing below, the patient agrees to the following terms:

- I acknowledge and accept financial responsibility for services rendered at CPRS.
- I authorize consent for the release of any medical information necessary to process insurance claims on my behalf.
- I authorize CPRS to correspond with my physicians(s) as indicated on this form.

Print patient name: ____

Signature: ______________________________ **Date:** ________________

David N. Hing, MD | Richard J. Beil, MD | Daniel G. Sherick, MD | Ali Charafeddine, MD

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

We may need access to your data as maintained by the PBM's to know what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance plan.

By signing below I give permission for Center for Plastic & Reconstructive Surgery to access my pharmacy benefits data electronically through RxHub. This consent will enable the Center for Plastic & Reconstructive Surgery to:

- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.
- Determine the pharmacy benefits and drug co-pays for a patient's health plan.

In summary, we ask your permission to obtain formulary information and information about other prescriptions prescribed by other providers using RxHub.

____ ____________________

Patient Name (PRINTED) Date of Birth

____ ____________________

Patient Signature Today's Date