

**DENVER PLASTIC SURGERY ASSOCIATES
PATIENT REGISTRATION INFORMATION**

Please print and complete all sections

Patient's Personal Information

Marital Status Single Married/Domestic Partner Divorced Widowed

Name _____ Sex M F
Last First In

How would you like to be addressed: _____

Address _____ Phone (home) _____

(work) _____

(cell) _____

Date of Birth ____/____/____ SS# ____/____/____ Occupation _____
Driver's License # _____ Issuing State _____

Name of Employer _____ F/ Time P/ Time e-mail _____

Spouse Name _____ Spouse's SS# ____/____/____ Spouse Daytime Phone ____-____-____

Responsible Party Information

e-mail address _____

Responsible Party _____ Date of Birth ____/____/____

Relationship to Patient Self Spouse Other SS# ____/____/____

Responsible Party's Phone Numbers (home) ____-____-____ (day time) ____-____-____

Address _____ City _____ State ____ Zip _____

Employer's Name _____ Phone ____-____-____

Occupation _____

Patient Insurance Information

HMO PPO EPO POS

PRIMARY Insurance Company Name _____

Insurance Address _____
Name of Insured _____ Date of Birth _____

Insurance ID # _____ Group # _____ Relationship to Insured: Self Spouse Child

Co-Pay \$ _____

HMO PPO EPO POS

SECONDARY Insurance Company Name _____

Insurance Address _____
Name of Insured _____ Date of Birth _____

Insurance ID # _____ Group # _____ Relationship to Insured: Self Spouse Child

Co-Pay \$ _____

PRIMARY CARE PHYSICIAN

Please note Referral and relationship

Primary Care Physician: _____ Referred by: _____ Relationship _____

EMERGENCY CONTACT

In Case of Emergency

Name _____ Phone _____ Relationship _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize Denver Plastic Surgery Associates to furnish any and all information, including but not limited to mental health records, drug and alcohol abuse records protected by law, and or HIV/AIDS test results, if any except as specifically provided below:

This authorization is effective now and will remain in effect until _____.

I understand that I may receive a copy of this authorization.

Patient Signature _____ Date _____

Responsible Party Signature _____ Date _____ Relationship _____

Patient Acknowledgement

I understand and acknowledge that my insurance coverage is a contract between my insurance company and me and that I am personally responsible for all medical expenses incurred during evaluation and treatment by Denver Plastic Surgery Associates. I understand that as a courtesy my primary insurance will be billed, however, it is my responsibility to follow up on delinquent claims. If I am a member of a PPO or an HMO I am required to make my co-pay and co-insurance payments in a timely fashion, and I am responsible for keeping my primary care physician referrals current. I authorize Denver Plastic Surgery associates to release all necessary medical information to my insurance carrier for processing my claims. I assign all benefits from said claims to Denver Plastic Surgery Associates. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient/Responsible Party _____ Date _____ Witness _____

**DENVER PLASTIC SURGERY ASSOCIATES
4600 Hale Parkway Ste. 330, Denver, CO 80220
303.320.8618**

Date: _____

It is helpful for us to know how you learned about Dr. Rodgers.

Please circle all statements that apply:

My friend _____ told me about the Dr. Rodgers.

My doctor _____ told me about the Dr. Rodgers.

Your location is convenient to my home or office.

I noticed your ad in the Yellow Pages / 5280 Magazine (circle one)

The hospital referral service recommended the doctor.

I read your newsletter.

I heard the doctor speak at _____

I was referred by my insurance company.

Internet search: (circle one)

Ienhance.com

PlasticSurgery.com

Association Website (i.e. American Association of Plastic Surgeons)

Inamed or Mentor implant website

Online Yellow Pages (i.e. DexOnline)

Search Engine (i.e. Google)

DenverPlasticSurgery.com

Other: _____

Other: _____

DENVER PLASTIC SURGERY ASSOCIATES

Christine Rodgers MD

History and Physical

Name: _____ Date: _____

SOCIAL

Age: _____ Sex: M F Married/Domestic Partner: Y N Occupation: _____

Responsible Adult Available to Assist During Recovery Period Y N Relationship: _____

HABITS

Smoke: Y N Amount: _____

Coffee/Tea/Cola: Y N Amount: _____

Alcohol: Y N Amount: _____

Daily Exercise: Y N Amount: _____

Drugs: Y N Amount: _____

Have you ever abused drugs or alcohol? Y N

MEDICATIONS: List dose or number of pills per day

Prescription Drugs

Non Prescription (Vitamins; Herbs)

Regular Aspirin Use: Y N Dosage & frequency: _____

NSA (Advil, Motrin, Ibuprofen): Y N Dosage & frequency: _____

Cortisone Injections Past Year: Y N Date(s) and injection location: _____

Drug Allergy: Y N List drug(s) and type of reaction, if tested by an allergist: _____

Latex Allergy: Y N Tape Allergy Y N

Anesthesia Reaction/Complication: Y N _____

Have you ever received a transfusion? Y N If yes, what year? _____ Hearing aid: Y N Dentures: Y N

Have you been tested for HIV? Y N If yes, what year _____ Test results: positive negative

Are you having ongoing Dental Work? Y N Are you experiencing an ongoing infection? Y N

Explanation: _____

FAMILY HISTORY: Have any blood relatives ever had the following problems:

Abnormal Bleeding: Y N Coronary Surgery: Y N Kidney Disease Y N

Abnormal Clotting: Y N Diabetes: Y N Tuberculosis: Y N

Anesthetic Problems: Y N Heart Attack: Y N Other Serious Illness: Y N

Cancer: Y N Hypertension: Y N

Please describe questions with a "Yes" answer: _____

PERSONAL PAST HISTORY: Have you ever had:

Abnormal Bleeding: Y N Asthma: Y N Hypertension: Y N

Abnormal Clotting: Y N Diabetes: Y N Sleep Apnea: Y N

Acid Regurgitation: Y N Fainting Spell: Y N Snoring: Y N

Anemia: Y N Heart Attack: Y N Weight Change past 12 Mo.: Y N

Angina: Y N Hepatitis: Y N Other Serious Illness: Y N

Cancer: Y N Radiation: Y N Chemotherapy: Y N

Please describe questions with a "Yes" answer: _____

Do you wear: Contact lenses: Y N Eye glasses: Y N Cataracts: : Y N Glaucoma: : Y N

Previous Surgery, year and type of procedure: _____

Date last seen by Primary Care Physician: _____

Primary Care Physician (name) _____ (telephone) (_____) _____

(address) _____

CURRENT MEDICAL HISTORY: _____

PAST SURGICAL HISTORY:

WOMEN PATIENTS ONLY:

Number of pregnancies _____ Number of children _____ Last menstrual period _____ Did you breast feed? Yes No

Name: _____ **MRN:** _____ **Date:** _____

Completed by Physician

REVIEW OF SYSTEMS

Loose Dental Devices:	Y <input type="checkbox"/> N <input type="checkbox"/>	Chest Pain:	Y <input type="checkbox"/> N <input type="checkbox"/>
Neck Mobility Problem:	Y <input type="checkbox"/> N <input type="checkbox"/>	Irregular Heart Beat:	Y <input type="checkbox"/> N <input type="checkbox"/>
Short Neck:	Y <input type="checkbox"/> N <input type="checkbox"/>	Vomiting:	Y <input type="checkbox"/> N <input type="checkbox"/>
Cough:	Y <input type="checkbox"/> N <input type="checkbox"/>	Difficult Voiding:	Y <input type="checkbox"/> N <input type="checkbox"/>
Shortness of Breath:	Y <input type="checkbox"/> N <input type="checkbox"/>	Seizure:	Y <input type="checkbox"/> N <input type="checkbox"/>
Recent Upper Respiratory Infection:	Y <input type="checkbox"/> N <input type="checkbox"/>	Current Pregnancy:	Y <input type="checkbox"/> N <input type="checkbox"/>
Normal Menstrual Period:	Y <input type="checkbox"/> N <input type="checkbox"/>	Black Out:	Y <input type="checkbox"/> N <input type="checkbox"/>
Stroke:	Y <input type="checkbox"/> N <input type="checkbox"/>	Obesity:	Y <input type="checkbox"/> N <input type="checkbox"/>

Comments: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Temp: _____

GENERAL STATUS COMMENT

HEENT: _____ Vision: _____ Pharynx: _____ Dental Devices: _____
Pulmonary: _____
Heart: _____
Abdomen: _____
Extremity: _____
Neurologic (if applicable): _____
Other: _____
Comments _____

LABORATORY (if applicable)

H/H: _____	CBC: _____
PT: _____	Chest X-Ray: _____
Mammogram: _____	EKG (Pt over 40): _____
Pregnancy Test: _____	Calcium: _____
SMA 6: _____	CO ₂ : _____
Comprehensive Chem Panel: _____	Creatinine: _____

Comments _____

DIAGNOSES

1. _____
2. _____
3. _____

ASA CLASSIFICATION

- P1 A normal healthy patient
- P2 A patient with mild systemic disease
- P3 A patient with severe systemic disease
- P4 A patient with severe systemic disease that is a constant threat to life

FACILITY SELECTED

Office-based Surgical Facility Ambulatory Surgery Center Hospital

PHYSICIAN SIGNATURE _____

Last Updated: 01/2008



ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received the *Notice of Privacy Policies* established for Denver Plastic Surgery Associates.

Patient Signature

Date

**DOCUMENTATION OF GOOD FAITH EFFORTS
TO OBTAIN PATIENT'S ACKNOWLEDGEMENT THAT THEY
HAVE RECEIVED PROVIDER'S
NOTICE OF PRIVACY PRACTICES**

For use when acknowledgement cannot be obtained from the patient.

This patient presented to our office on _____ and was provided with a copy of our *Notice of Privacy Policies*. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- Patient refused to sign
- Patient was unable to sign or initial because:

- The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.
- Other reason:

Signature of Employee

Date

DENVER PLASTIC SURGERY ASSOCIATES

TO OUR PATIENTS

Some of the procedures performed by Dr. Rodgers are considered totally or partially cosmetic.

There are no “usual, reasonable, and customary” charges for such procedures as they are not covered by insurance. If you have any questions regarding our charges, please discuss these with the Doctor prior to your treatment.

Payment is expected at, or prior to, the time of the service unless other arrangements have been made in advance.

Signature

Date

TO INSURANCE COMPANIES

I also request payment of medical benefits to the party below.

Christine M. Rodgers, M.D.

Signature

Date

AUTHORIZATION AND FINANCE CHARGE

If I do not pay the entire new balance within 25 days of the monthly billing date, a finance charge can be added to the account for the current monthly billing period. The finance charge will be at a periodic rate of 1.5% per month or a minimum charge of \$2.00 for a balance under \$134.00 which is an annual percentage rate of 18% applied to the last months balance. In the case of default of payment, all costs of collection and reasonable attorneys fee will be added to this account.

Signature

Date

Relationship to patient: Self _____ Spouse _____ Parent _____ Guardian _____



AESTHETIC
ORIGINS

SKINCARE

dermal fillers [juvederm , restylane]

IPL fotofacial skin rejuvenation

professional skincare products

microdermabrasion

Javani® deep hydration facial

DiamondTOME™

chemical peels

botox

303.320.8618 | 4600 Hale Parkway Suite 330: Denver, CO 80220 | www.denverplasticsurgery.com



Would you like to receive offers and news from our medical skincare clinic, *Aesthetic Origins*?

Now you can receive these great offers straight to your e-mail address! Our aesthetician offers the latest technology in skincare and rejuvenation services with your safety in mind.

Your e-mail will not be shared with anyone outside our office and will only be used to notify you of offers for Aesthetic Origins.

Yes, I authorize you to send me monthly *Aesthetic Origins* offers.

(Please print all information clearly)

My e-mail address is _____

Please print your name _____

No, I am not interested at this time.