



PATIENT INFORMATION (PLEASE COMPLETE ENTIRE FORM)

Name Last _____ First _____ MI _____

Address _____ City _____

Email _____ State _____ Zip _____

Home Phone# (____) _____ Work#(____) _____ Cell#(____) _____

Best number to reach you and/ or leave a message _____ SS# _____

Date of Birth ____/____/____ Age _____ Gender: M F Marital Status: S M D W Sep

How did you hear about ZPS? _____

Referring MD _____ Phone# _____

Would you be interested in a complimentary skin care consultation with our aesthetician? Yes No

PATIENT EMPLOYMENT INFORMATION

Employer Name _____ Occupation _____

Employer Address _____ City/State/Zip _____

INSURANCE INFORMATION OF POLICY HOLDER

Primary Insurance _____ ID# _____

Name(Policy Holder) _____ SS# _____ Date of Birth ____/____/____

Address _____ City/State _____ Zip _____

Relationship to Patient _____ Telephone# ____/____/____

Employer _____ Work# ____/____/____

Employer's Address _____ City/State _____ Zip _____

Secondary Insurance _____ ID# _____

Name of Policy Holder _____ Date of Birth _____

EMERGENCY CONTACT INFORMATION

Name _____ Phone#(____) _____ Relationship to patient _____

I hereby authorize payment of medical benefits billed to my insurance company to be paid directly to Zinsser Plastic Surgery, P.C. I agree to pay all co-payments and deductibles, as well as cosmetic services, at the time services are rendered. I agree to pay a \$50.00 service charge for each NSF check issued. In the event that my account is turned over to collection, I am responsible for attorney's fees, court costs, and any other charges incurred in collecting the balance due.

Signature of patient (if over 18) or patient's parent/legal guardian Date

ZINSSER PLASTIC SURGERY, P.C.

FINANCIAL AGREEMENT

Each patient must provide their insurance card and pictured identification to the receptionist for photocopying at each appointment. In the event that no insurance is available, or it has been determined that the patient is ineligible for coverage of services, this account will be determined to be self-pay and payment in full is due at the time of each service.

Zinsser Plastic Surgery, P.C. accepts the following insurances: AETNA, ANTHEM, CIGNA, VHN, UHC, MEDICARE, SENTARA/OPTIMA, and SOUTHERN HEALTH. Patients that have other insurance (non-participating) assume all financial responsibilities for any charges incurred which are not covered by the insurance company.

I HEREBY AUTHORIZE Zinsser Plastic Surgery, P.C. to release medical information to my physicians and/or insurance company(ies). I further authorize direct payment from my insurance company(ies) to Zinsser Plastic Surgery, P.C.

I understand that I am responsible for obtaining all necessary referrals prior to the scheduled appointment. All co-payments required by my insurance plan will be paid at the time of service. I further acknowledge that all deductibles, co-insurance and non-covered items as determined by my insurance plan will be due and payable upon notice either sent by U.S. mail in the form of a statement and/or telephone communication from Zinsser Plastic Surgery, P.C. I understand that any unpaid charges for "out of network" procedures are my responsibility. I also understand that it is my responsibility, not Zinsser Plastic Surgery, P.C. to contact my plan to inquire about my financial obligation regarding non-participation benefits.

After the first missed appointment without 24-hour notice given to Zinsser Plastic Surgery, P.C., I will be charged a \$50 no show fee.

All returned checks shall be assessed a \$50.00 bank processing fee, for which I will be responsible.

I further agree that if this account is not paid when due I will be responsible for all collection costs incurred by Zinsser Plastic Surgery, P.C.

Zinsser Plastic Surgery, P.C. reserves the right to assess a charge for telephone calls when medical care is dispensed in lieu of an office visit.

Responsible Party (Parent or Guardian)

Date

Zinsser Plastic Surgery, P.C.

Written Authorization Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected medical information (PHI) about you. As provided in our notice, the terms of our privacy practices may change. If we change our policies, you may obtain a revised copy.

I, _____

Patient Name

Parent/Guardian

Have read and/or received a copy of Zinsser Plastic Surgery's Notice of Privacy Practices. I have had an opportunity to read the Notice of Privacy Practices. I understand that I may ask questions of Zinsser Plastic Surgery if I do not understand any information contained in the Notice of Privacy Practices.

I give Zinsser Plastic Surgery authorization to disclose information about my treatment/records to the following people:

_____ Phone _____

_____ Phone _____

_____ Phone _____

I understand that photographs, digital, or other images may be recorded to document my care, and provide education, and I consent to this. I understand that Zinsser Plastic Surgery will retain the ownership rights to these photographs, or other images, but I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and neither I nor any member of my family, will be identified by name.

I understand that photographs, digital, or other images may be recorded to document my care, provide education and or be used on Dr. John Zinsser's web-site.

Agree

Disagree

Patient/Parent or Guardian/ Authorized Representative

Date _____ Relation _____

History and Physical
Patient Name _____

Date _____

Age _____ **HT** _____

PART 1 HISTORY
WT _____

The following questions are to be filled out by the patient—please answer all questions by checking box YES () or NO (). Any positive responses will be discussed with you by Dr. Zinsser.

LUNGS	YES	NO
Born with any lung disease	()	()
Cough or cold at present	()	()
Bronchitis	()	()
Asthma	()	()
Emphysema	()	()
Smoke _____ packs cigarettes Per day for the past _____ years	()	()

HEART	YES	NO
Born with any heart disease	()	()
Heart murmur	()	()
Rheumatic fever	()	()
High Blood Pressure	()	()
History Chest Pain	()	()
History Heart Attack	()	()
Heart failure	()	()
Skipped heart beats	()	()
Hardening of arteries	()	()

BLOOD	YES	NO
Sickle cell trait/disease	()	()
Abnormal blood clotting	()	()
Other disease of blood cells	()	()

LIVER	YES	NO
Jaundice	()	()
History of hepatitis	()	()
Drink alcoholic beverages	()	()
Other liver disease	()	()

IF YOUR CONDITION IS DUE TO AN ACCIDENT
When it happened: _____

Where it happened: _____

Describe: _____

NERVOUS SYSTEM	YES	NO
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Epilepsy	()	()
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Stroke	()	()
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Neuropsychiatric disorder	()	()
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ENDOCRINE	YES	NO
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Diabetes (blood sugar)	()	()
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Thyroid disorder	()	()
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Metabolic disorder	()	()
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Malignancy	()	()
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EYE	YES	NO
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Glaucoma	()	()
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Wear contact lenses	()	()
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Dryness and/or burning	()	()
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STOMACH/BOWEL OR GALLBLADDER HISTORY	YES	NO
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REPRODUCTIVE	YES	NO
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Female: Are you pregnant?	()	()
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Are you trying to become pregnant?	()	()
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Breast: history of breast disease?	()	()
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Do you have breast implants?	()	()
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Date of last mammogram	_____
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KIDNEY	YES	NO
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History of kidney stones or infection	()	()
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IF YOU HAVE ANY MEDICAL PROBLEMS NOT INCLUDED ON THIS CHECKLIST, PLEASE EXPLAIN:

SKIN

	YES	NO
Have you used Accutane in the last 12 months	()	()
Do you have a history of fever blisters	()	()
Do you have a history of any skin disorders/skin cancer	()	()
Do you have a history of scarring or poor wound healing	()	()
Do you use sunscreen: Always () Sometimes () Never ()		

LIST PREVIOUS SURGERIES AND APPROXIMATE DATES

	YES	NO
Did you have any complications after surgery?	()	()
Post-operative bleeding problems or blood clot?	()	()
Infection?	()	()
Keloids or thick scars?	()	()

ANESTHETIC HISTORY

Allergy to any drug used in dental work, anesthesia or surgery	()	()
Any blood relatives have an allergy to any drug used in surgery	()	()
Any problems resulting from any local or general anesthesia	()	()
History of Post-operative nausea and vomiting	()	()

DO YOU HAVE SLEEP APNEA?	()	()
IF YES, DO YOU WEAR A C-PAP MASK	()	()
DO YOU BRUISE OR BLEED EASILY?	()	()

WHO IS YOUR MEDICAL DOCTOR? (first and last name please) _____

Address and phone _____

LIST ALL PRESENT MEDICATIONS (attach list if needed)

Especially important are: Cortisone, aspirin or medications containing aspirin, blood thinners, heart medications, water pills (diuretics), antidepressants, sedatives, tranquilizers, hormones, birth control pills, etc.

DO YOU HAVE ANY DRUG OR FOOD ALLERGIES? If so, please list: _____

PATIENT'S SIGNATURE: _____
(If patient is a minor, parent or legal guardian signature)
