Zinsser Plastic Surgery
1501 Maple Avenue, Suite 101B
Richmond, VA 23226
Phone (804) 474-9805
www.zinsserplasticsurgery.com

ZINSSER
PLASTIC SURGERY

Patient Information Form

Last Name: _____ First Name: _____ MI: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Cell Carrier: _____

Marital Status: _____ SSN: _____ Gender: _____

Ethnicity: Hispanic or Latino ☐ **No** ☐ **Yes** Race: _____ Preferred Language: _____

DOB: _____ Age: _____ Email Address: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

How did you hear about us? _____

Are you coming in for a work-related injury? ☐ **No** ☐ **Yes**, date of injury: _____
Primary care physician: _____
Referring provider / other: _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Assignment and Release

I,_____ , have insurance coverage and assign directly all medical benefits billed to my insurance company to be paid directly to Zinsser Plastic Surgery. I understand that I am financially responsible for all charges whether or not paid by insurance and personal checks are not accepted for office procedures. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured / Guardian Date

Primary Insurance

Company Name: _____ Policy #: _____ Group ID: _____
If responsible party is someone beside the patient, please fill in the following fields:
Policy holder's name: _____ Relationship to patient: ☐ Spouse ☐ Other: _____
Phone #: _____ DOB: _____ SSN: _____

Secondary Insurance

Company Name: _____ Policy #: _____ Group ID: _____
If responsible party is someone beside the patient, please fill in the following fields:
Policy holder's name: _____ Relationship to patient: ☐ Spouse ☐ Other: _____
Phone #: _____ DOB: _____ SSN: _____

Zinsser Plastic Surgery
1501 Maple Avenue, Suite 101B
Richmond, VA 23226
Phone (804) 474-9805
www.zinsserplasticsurgery.com

ZINSSER
PLASTIC SURGERY

WHAT IS THE NATURE OF YOUR VISIT?

Section I: Surgery and Anesthesia History

1. Have you ever had surgery? ☐ **Yes** ☐ **No**, if yes please describe and provide year performed:

_____

_____

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ **Yes** ☐ **No**, if yes please describe:

_____

Section II: Specific Medical History

Height: _____ **Weight:**_____

	Have you or do you still have:	**Yes**	**No**	**Description**
1.	Asthma	☐	☐	
2.	Tuberculosis	☐	☐	
3.	High Blood Pressure	☐	☐	
4.	Coronary Artery Disease	☐	☐	
5.	Heart Trouble	☐	☐	
6.	Mitral Valve Prolapse	☐	☐	
7.	HIV / AIDS	☐	☐	
8.	Hepatitis or Liver Trouble	☐	☐	
9.	Anemia	☐	☐	
10.	Bleeding Tendency	☐	☐	
11.	Diabetes	☐	☐	
12.	Stroke	☐	☐	
13.	Thyroid Trouble	☐	☐	
14.	Arthritis	☐	☐	
15.	Glaucoma	☐	☐	
16.	Kidney Trouble	☐	☐	
17.	GERD	☐	☐	
18.	Cancer	☐	☐	
19.	Melanoma	☐	☐	
20.	Breast Cancer	☐	☐	
21.	Others Not Listed:			

Zinsser Plastic Surgery
1501 Maple Avenue, Suite 101B
Richmond, VA 23226
Phone (804) 474-9805
www.zinsserplasticsurgery.com

ZINSSER
PLASTIC SURGERY

Section III: Skin History

1. Have you used Accutane in the last 12 months? ☐ **Yes** ☐ **No**
2. Do you have a history of fever blisters? ☐ **Yes** ☐ **No**
3. Do you have a history of any skin disorders / skin cancer? ☐ **Yes** ☐ **No**
4. Do you have a history of scarring or poor wound healing? ☐ **Yes** ☐ **No**

Section IV: Social History

1. Do you smoke? ☐ **Yes** ☐ **No**, how much? _____
2. Do you drink? ☐ **Yes** ☐ **No**, how much? _____
3. Do you have children? ☐ **Yes** ☐ **No**, how many? _____

Section V: Family History

Have any blood relatives had any of the following?	Yes	No	Description
1. Cancer	☐	☐	
2. Breast Cancer	☐	☐	
3. Heart Disease	☐	☐	
4. High Blood Pressure	☐	☐	
5. Melanoma	☐	☐	
6. Stroke	☐	☐	
7. Kidney Disease	☐	☐	
8. Depression	☐	☐	

Section VI: Review of Systems

Do you have now or have you had within the past year:

	Yes	No		Yes	No		Yes	No
Weight change	☐	☐	Swollen feet/ankles	☐	☐	Seizures	☐	☐
Dry eyes	☐	☐	Skin rash	☐	☐	Joint or muscle pain	☐	☐
Chronic cough	☐	☐	Chronic diarrhea	☐	☐	Swollen lymph nodes	☐	☐
Chest pain	☐	☐	Jaundice	☐	☐	Easy bleeding	☐	☐
Rapid heart beat	☐	☐	Depression	☐	☐	Easy bruising	☐	☐

Zinsser Plastic Surgery
1501 Maple Avenue, Suite 101B
Richmond, VA 23226
Phone (804) 474-9805
www.zinsserplasticsurgery.com

ZINSSER
PLASTIC SURGERY

Section VII: Women Only

Age period began: _____

Number of pregnancies: _____

Date of last mammogram: _____

Did you breast feed: ☐ **Yes** ☐ **No**

Do you do regular breast self-examinations? ☐ **Yes** ☐ **No**

Breast lump or discharge: ☐ **Yes** ☐ **No**

Are you pregnant? ☐ **Yes** ☐ **No**

Section VIII: Medications

Are you taking any medications, vitamins or herbal supplements? ☐ **Yes** ☐ **No**, if yes please list (include dosage):

_____

_____

Please provide your pharmacy name and location: _____

Section IX: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ☐ **Yes** ☐ **No**, if yes please list:

	Medication Name	Reaction	Severity	Comments
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Zinsser Plastic Surgery
1501 Maple Avenue, Suite 101B
Richmond, VA 23226
Phone (804) 474-9805
www.zinsserplasticsurgery.com

ZINSSER
PLASTIC SURGERY

Consent to Communicate

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐**Yes** ☐**No**	☐	
☐ Call Cell Phone	☐**Yes** ☐**No**	☐	
☐ Call Home Phone	☐**Yes** ☐**No**	☐	
☐ Send Email		☐	-
☐ Email Appointment Reminders			
☐ Email Medical Information			
☐ Email Office Specials			
☐ Send Regular Mail		☐	-
Mail to which Address: ☐ Home ☐ Other (please list):			
☐ Send Text Message – if so, list cell carrier:		☐	-
☐ Text Appointment Reminders			
☐ Text Medical Information			

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐**Yes** ☐**No**	
			☐**Yes** ☐**No**	

Signature: _____ Date: _____

Zinsser Plastic Surgery
1501 Maple Avenue, Suite 101B
Richmond, VA 23226
Phone (804) 474-9805
www.zinsserplasticsurgery.com

ZINSSER
PLASTIC SURGERY

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office or on our website at www.zinsserplasticsurgery.com

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. We agree to provide patients with access to their records in accordance with state and federal laws.

7. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

8. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I,_____ , do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes of office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____