COLUMBIA
PLASTIC SURGERY

Dr. John D. Newkirk, PhD, MD
3020 Sunset Blvd. Suite 100
West Columbia, SC 29169

Patient's Name: _____ Date: _____
SS#:_____

Address: _____

City_____ State:_____ Zip: _____

Cell Phone: (____)_____ Home Phone (____)_____

Age: _____ DOB: _____ Marital Status:_____ Sex:_____

Email:_____

Employer: _____ Next of Kin: _____
Business Phone:(____)_____ Relationship:_____ Phone: (____)_____

Health Insurance Information: This section does not apply to cosmetic patients. Please fill out all the information completely and correctly to assist in having your procedure covered.

Primary Insurance: _____
Sponsor: _____ Sponsor's DOB: _____
Policy or ID#: _____

Group Name: _____ Group #:_____

Secondary Insurance: _____
Sponsor: _____ Sponsor's DOB: _____
Policy or ID#: _____

Group Name: _____ Group #:_____

How did you hear about us? _____

Allergies:
Any drug allergies? Yes No
If yes, please list drug and reaction
_____
Latex or tape allergies? Yes No

Social:
Do you smoke/use tobacco products?_____
Types/packs per day?: _____

Do you consume more than one alcoholic beverage per day? Yes No

If yes, how much?:_____

Family History:
Any medical problems or illnesses in your family? Yes No
If yes, please explain:_____

Any family history of forming keloids/thick? Yes No
Any family history of bleeding disorders? Yes No
Any family experience unusual healing problems? Yes No

Medications:
Currently taking aspirin containing medications? Yes No
Currently taking any blood thinning medications? Yes No
Currently taking any birth control medications? Yes No
Taken any steroid preparation in the past year? Yes No

List any medications and vitamins you are currently taking or have taken within the last month & the dosage: _____
_____
_____

Females:
Last menstrual period:_____

Have you had a mammogram? Yes No
If yes, when? _____

Taken or are currently using Acutane? Yes No
Have you had children? Yes No

Mental History:
Are you currently seeing a psychiatrist? Yes No
Any history of mental illness? Yes No
If yes, please explain: _____

Chest:

Coronary/heart attack:	Yes	No
Angina/chest pain:	Yes	No
Congenital heart disease (at birth):	Yes	No
Heart murmur:	Yes	No
Prolapsing valve:	Yes	No
Stroke:	Yes	No
Hypertension:	Yes	No
Shortness of breath:	Yes	No
Chronic lung disease:	Yes	No
Palpitations/irregular heartbeat:	Yes	No
Panic Attacks:	Yes	No
Asthma:	Yes	No

General:
Family doctor:_____
How is your health?:_____

Are you currently being treated for any condition? Yes No
If yes, please specify:_____
Last physical exam:_____ Height:_____ Weight:_____
Date of your last tetanus shot:_____
Problems with anesthesia? Yes No

Seizures or epilepsy:	Yes	No	Addison's or adrenal disorder:	Yes	No
Thyroid disorder:	Yes	No	Skin problems:	Yes	No
Liver disorder:	Yes	No	Gastrointestinal disorder:	Yes	No
Kidney/bladder disorder:	Yes	No	Spinal or back disorder:	Yes	No
HIV positive:	Yes	No	Glaucoma:	Yes	No
Sinus issues:	Yes	No	Blood clots:	Yes	No
Vein disorder:	Yes	No	Diabetes:	Yes	No
Healing disorder:	Yes	No	Keloids or thick scars:	Yes	No

If you answered yes to any of the above, please explain:_____
_____

Previous surgeries, hospitalizations, and/or pregnancies:
Please list type, where it was performed, the physician, and any type of complication
_____
_____
_____

Consent to Photograph Release

In planning your surgery, clinical pre-operative and post-operative photographs are necessary. These photographs will be used exclusively by your surgeon and remain part of your permanent medical record. On occasion, such photographs may be used for clinical education purposes as well. Photographs may also be used for clinical purposes on our website. In consenting to have your photographs taken, you attest that you understand and agree to such use.

( ) I consent to having clinical photographs obtained and allow their use for clinical education purposes and to be used on the Columbia Plastic Surgery website.

( ) I consent to having clinical photographs obtained, but **DO NOT** wish for these photographs to be used for clinical educational purposes or on the Columbia Plastic Surgery website.

I have read and understand the above policies of Columbia Plastic Surgery, PC and agree to fulfill all obligations as outlined.

Signature:_____ Date:_____
Patient/Responsible Party

Columbia Plastic Surgery, PC
Dr. John D. Newkirk

Payment Agreement

I hereby authorize Columbia Plastic Surgery, PC to submit a claim to my insurance carrier or to Medicare for all the covered services which have been rendered and direct my insurance carrier to issue payment to Columbia Plastic Surgery, PC. I further authorize the release of any medical information needed by the above to intermediaries to pay an insurance claim.

I agree to be responsible for 40% collections cost (collection agency fees, attorney fees, and court cost) incurred in collecting a delinquent account.

Columbia Plastic Surgery, PC will not bill your health insurance for cosmetic surgery.

I understand I am responsible for any charges that are considered cosmetic and are self-pay.

I am aware that Columbia Plastic Surgery, PC holds me responsible for canceling any appointment I am unable to keep and understand that if I fail to provide the staff with at least a 24-hour notice, I will be charged and held responsible to pay a fee of $50.00.

I herby certify that I have read this agreement and have had the opportunity to clarify any questions I might have.

_____ _____

Signature of patient/ parent/guardian Date

Columbia Plastic Surgery, PC
Dr. John D. Newkirk

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding any protected health information. I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved directly or self pay.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operation such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to address the above or obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that identity of designated partied must be verified before the release of any information.

Authorized Designees: (Friend or Relative)

Name: _____ Relationship: _____

I do not wish to authorize designees: _____

Patient Signature: _____ Date: _____