# *St. Petersburg Center for Plastic Surgery*

## JOHN J. O'BRIEN, Jr., M.D.



**Social Security #**_____ **Date**_____

**Patient's Name**_____
**(First) (Middle Initial) (Last)**

**Age**_____ **Date of Birth**_____ **Married**____**Single**____**Widowed**____**Divorced**____**Separated**_____

**Local Address**_____

**City**_____**State**_____**Zip**_____**Phone w/Area Code**_____

**Permanent Address**_____

**City**_____**State**_____**Zip**_____**Phone w/Area Code**_____

**Patient's Occupation**_____ **Employer**_____

**Business Address**_____**Bus. Phone**_____**Ext.**_____

**Name of Spouse**_____**Spouse Occupation**_____

**Spouse Employer**_____**Bus.Phone**_____**Ext.**_____

**Patient Referred By**_____ **Email address:**_____

**Family Doctor or Primary Care Physician**_____**Phone w/Area Code**_____

**Has our office seen/treated any member of your family? No**_____ **Yes**_____ **If "yes", whom?**_____

**Emergency contact name and phone**_____

**Please Check: Group Insurance**_____ **Medicare**_____ **Workman's Comp.**_____ **Accident**_____

**Insurance Company**_____**Phone w/Area Code**_____
**Please Submit Insurance Card to Receptionist for Copy**

**Pharmacy Name and Address:**_____

**If Workman's Compensation:**
**Date of Injury**_____**Employer**_____**Phone w/Area Code**_____
**If Accident:**
**Date of Injury**_____**Insurance Co.**_____**Phone w/Area Code**_____

**Person Financially Responsible: Patient**_____ **Spouse**_____ **Other**_____
**If "Other", please complete the following:**

**Name**_____**Relationship**_____

**Address**_____

**Occupation**_____**Employer**_____**Phone w/Area Code**_____

**Specific reasons/interest(s) for which you are seeing Dr. O'Brien today:** _____

_____

**Have you consulted with any other doctors, including plastic surgeons about this? No**_____ **Yes**_____
**If "yes", please list their names**_____

## INJURIES

| Type | Date | Hospital | Doctor | After Effects |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## FAMILY HISTORY

| | Age | State of Health | Please check if there is a history of the following in your family and who it affected - | | |
|---|---|---|---|---|---|
| Mother | | | Tuberculosis | No | Yes |
| Father | | | Cancer | No | Yes |
| Brother(s) | | | Diabetes | No | Yes |
| | | | Epilepsy | No | Yes |
| Sister(s) | | | Heart Disease | No | Yes |
| | | | High Blood Pressure | No | Yes |
| Children | | | Lung Disease | No | Yes |
| | | | Kidney Disease | No | Yes |
| | | | Blood Disease | No | Yes |
| | | | Asthma | No | Yes |
| | | | Mental Disease | No | Yes |

## MEDICATIONS, DRUGS

**What is your approximate daily consumption of the following:**

**Tobacco**_____

**Alcohol**_____

**Coffee or Tea**_____

**Please list all medications you are now taking (including birth control pills, diuretics (water pills), blood pressure or heart medications, tranquilizers, hormones, blood thinners, Coumadin, aspirin containing products, herbal supplements or diet medications.**

## PERTINENT INFORMATION

**Are you pregnant?** **No_____ Yes_____**

**Are you allergic to any medicines?** **No_____ Yes_____**

**If "yes", which one(s)?_____**

**_____**

**What type of Allergy? e.g., rash, nausea, etc._____**

**Have you ever had skin cancer of any type?_____No_____Yes____**
**Have you ever had a bad reaction to a general anesthetic? (gas, Pentothal, etc.)?___No_____Yes____**
**Has any member of your family ever had any bad reaction to a general anesthetic? No_____Yes____**
**Have you required unusually large amounts of local anesthetic for medical or Dental procedures? _____ No_____Yes____**
**Have you ever had a bad reaction to a local anesthetic (Novocain, etc.)?_____No_____Yes____**
**Are you allergic to adhesive tape?_____ __No_____Yes____**
**Do you have high blood pressure?_____ __No_____Yes____**
**Have you ever had Scarlet fever or Rheumatic Fever?_____No____Yes____**
**Do you bleed unusually easily (from cuts, surgery, tooth extractions)?_____ ___No____Yes____**
**Do you bruise unusually easily?_____No____Yes____**
**Are you a slow or poor healer?_____No____Yes____**
**Do you form large scars or keloids?_____No____Yes____**
**Do you have any skin disease, hives, eczema or rash?_____No____Yes____**
**Do you have frequent infections or boils?_____No____Yes____**
**Have you taken steroid medications, cortisone or ACTH?_____No____Yes____**
**Do you have shortness of breath with walking?_____No____Yes____**
**Do you have, or have you had, any significant emotional problems?_____No____Yes____**
**Have you ever had psychiatric care?_____No____Yes____**
**Have you ever been advised to see a psychiatrist?_____No____Yes____**

**Have you had any illnesses (including cancer) of the following? (Circle if Yes)**

**Brain Nose Chest Stomach Bladder Arms Eyes Throat**

**Lungs Skin Intestines Reproductive System Legs Ears Neck**

**Heart Kidney Nervous System**

**If circled, please explain: _____**

**Signature of Patient _____**

**Relationship to Patient_____**
**(Self, Mother, Father, Guardian, etc.)**

## PAST MEDICAL HISTORY

**General Health:** **Good_____** **Fair_____** **Poor_____**

**If not "Good", please explain:** _____
_____
_____
_____
_____

**Height_____** **Weight_____**

**How long ago was your most recent physical examination?** _____
**Did it include an electrocardiogram? No_____ Yes_____** **Chest x-ray? No_____ Yes_____**
**Did it include a mammogram? No_____ Yes_____** **Results_____**

**Name, address and phone of Doctor:** _____
**(Name)** **(Address)** **(Phone)**

**Serious Illnesses (Please list)** _____
_____
_____
_____
_____

**Previous Surgery (Please list)**

| Operation | Year | Hospital | City | Surgeon's Name | Anesthesia (Local or General) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Previous Plastic Surgery (Please Circle)**

**Facelift, Browlift, Upper or Lower Eyelids, Nasal Surgery, Liposuction (list area), Breast Lift, Breast Augmentation (Implants), Other**

_____
_____
_____
_____

**Have you had significant complications or after effects from any of these operations? No____ Yes___**

**If "Yes", please explain:** _____
_____
_____
_____
_____

# YOU, YOUR INSURANCE COMPANY AND THE OFFICE OF JOHN J. O'BRIEN, JR., M.D.

## PATIENT AGREEMENT

I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL REGARDLESS OF WHETHER INSURANCE REIMBURSES OR NOT.

I HEREBY UNDERSTAND AND AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY INSURANCE REGARDLESS OF ANY INSURANCE COMPANY'S ARBITRARY DETERMINATION OF USUAL AND CUSTOMARY RATES. I UNDERSTAND AND WILL PAY ALL CO-PAYS AND DEDUCTIBLES PRIOR TO TREATMENT IF DR. O'BRIEN PARTICIPATES IN MY INSURANCE PLAN. IF DR. O'BRIEN IS **NOT** A PARTICIPATING PROVIDER IN MY INSURANCE PLAN, I UNDERSTAND THAT FEE FOR SERVICES IS PAYABLE ON THE DAY SERVICE IS PROVIDED.

I hereby authorize assignment and payment of benefits directly to Dr. O'Brien for major medical benefits due me. I authorize use of my signature as proof of signature on file for all of my insurance submissions. I hereby authorize Dr. O'Brien to release information requested by my insurance company, auto insurance carrier or Workers' Compensation carrier. I also authorize Dr. O'Brien to release information to any hospital or physician I may be referred to by this office and to use my chart for peer reviews. Occasionally, insurance companies will attempt to delay payment by asking for unnecessary records or stating they have not received the claim or it is "pending review." In these instances we may ask you to contact your insurance carrier or your personnel department for help in payment of the claim.

I authorize Dr. O'Brien to take medical photography. Medical photographs may be used for medical meetings, publications and/or insurance documentation. I hereby release Dr. O'Brien from all legal responsibilities or liabilities that may arise from this authorization.

**My signature on this document is acknowledgement of my informed consent that the office of John J. O'Brien, Jr., M.D. has explained to me that I am responsible for payment to any and all providers for any covered services which my insurance company may determine to NOT be medically necessary or NOT reasonable and customary or NOT covered by my insurance company. This includes deductibles, co-payments or balances NOT paid by my insurance company. All fees for any and all cosmetic procedures are my full responsibility. Medical services, supplies and drugs/devices are provided without guarantee of outcome or patient satisfaction. There will be no refund of scheduling fees, payment for professional services or supplies. Services that are paid with a credit card, debit card or financing are not eligible for credit card challenge. In signing this agreement, the responsible party and/or patient will not challenge credit card payments once the service is provided. I agree that this credit, debit card or financing challenge agreement is irrevocable.

In the event my account, with Dr. John J. O'Brien, Jr., becomes delinquent and it is necessary for my account to be placed with a collection agency, a **40%** COLLECTION FEE WILL BE ADDED TO MY BILL AS WELL AS ATTORNEY FEES.

PATIENT'S NAME(PRINT) _____ SIGNATURE_____

DATE: _____ SIGNATURE OF WITNESS_____

My signature represents my agreement to abide by and uphold the above agreement.

# *St. Petersburg Center for Plastic Surgery*
# *John J. O'Brien, Jr., M.D.*

## PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operation, in order to provide health care that is in your best interest. This includes disclosures to medical insurance, banking and credit companies and credit card companies.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our policy notice.

_____

Patients Printed Name Signature Date

**COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS**

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients' inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctor continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises of policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

**Thank you for being one of our valued patients**.