PATIENT INFORMATION

Last Name	First Name	Middle or Maiden
Social Security #	Sex / DOB	Age
Home Address	Apt # / City / State	Zip
Home Phone #	Cell Phone #	
Name of Employer	Work Phone #	
Marital Status	Race	

Guarantor (policyholder of primary insurance)

Last Name	First Name	Middle or Maiden
Social Security #	Sex / DOB	Age
Home Address	Apt # / City / State	Zip
Home Phone #	Work Phone #	Cell Phone #
Name of Employer	Employer Address	

Emergency Contact Information

Emergency Contact Name	Relationship to patient	
Mailing Address	Home Phone #	Cell Phone #

Insurance Information

Primary	Secondary
Insurance Co. Name	Insurance Co. Name
Address	Address
City, County, State, Zip	City, County, State, Zip
Insured's Last Name First	Insured's Last Name First
Group Number	Group Number
Policy # or SS #	Policy # or SS #
Relationship to insured	Relationship to insured
Employer	Employer
Phone	Phone

Carolinas HealthCare System

Carolinas Healthcare Medical Group
PATIENT INFORMATION SHEET

Patient Information or Sticker

Name:

DOB:

Medical Record #:

CMC Cosmetic and Plastic Surgery

1025 Morehead Medical Drive, Suite 200 • Charlotte, NC 28204
Phone: (704) 446-6810 • Fax: (704) 355-2467

Name: _____ Date: _____

Primary Care Physician: _____ Referring Physician: _____

Reason for visit: _____

Physician ONLY:

(HPI: Location, Duration, Timing, Severity, Quality, Modifying Factors, Associated Signs and Symptoms, Context)

Current Medications (Including Over the Counter Meds and Herbals):

_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES: _____

Past Medical Illnesses / Hospitalizations (Non-Surgical) and Approximate Dates:

_____ _____
_____ _____
_____ _____
_____ _____

Previous Surgeries and Approximate Dates:

_____ _____
_____ _____
_____ _____

Have you ever had any of the following?

Stroke	☐No ☐Yes	HIV+ or AIDS	☐No ☐Yes	Bleeding Tendency	☐No ☐Yes
Heart Disease	☐No ☐Yes	Glaucoma	☐No ☐Yes	Thyroid Disease	☐No ☐Yes
Stomach Ulcers	☐No ☐Yes	Cancer	☐No ☐Yes	Rheumatic Fever	☐No ☐Yes
Hepatitis	☐No ☐Yes	Asthma	☐No ☐Yes	High Blood Pressure	☐No ☐Yes
Arthritis	☐No ☐Yes	Sleep Apnea	☐No ☐Yes	Tuberculosis	☐No ☐Yes
Anemia	☐No ☐Yes	Blood Clots	☐No ☐Yes	Diabetes	☐No ☐Yes

870

Carolinas HealthCare System

CMC Cosmetic and Plastic Surgery
Medical History

Patient Information or Sticker

Name:

DOB:

Medical Record #:

Family History:

Please place a check mark if any blood relative has had any of the following:

☐ Breast Cancer	☐ Melanoma	☐ Diabetes
☐ High Blood Pressure	☐ Ovarian Cancer	☐ Heart Disease
☐ Hemophilia	☐ Blood Clots	☐ Colon Cancer
☐ No Known Conditions	☐ Other _____	
☐ Problems with Anesthesia	_____	

Social History:

Do you currently smoke? ☐No ☐Yes If yes, amount per day _____
Are you a former smoker? ☐No ☐Yes If yes, when did you quit? _____
Do you drink alcohol? ☐No ☐Yes If yes, amount per week _____
Occupation: _____
Marital Status: ☐M ☐D ☐S ☐W
Number of Children: _____
Do you plan on having more children? ☐No ☐Yes

Review of Systems:

Please check YES or NO if you have had any of the following symptoms in the past year:

Weight Changes	☐No	☐Yes	Nausea/Vomiting	☐No	☐Yes
Chest Pain	☐No	☐Yes	Rapid Heart Beat	☐No	☐Yes
Jaundice	☐No	☐Yes	Depression	☐No	☐Yes
Seizures	☐No	☐Yes	Easy Bleeding	☐No	☐Yes
Joint Pain	☐No	☐Yes	Muscle Pain	☐No	☐Yes
Chronic Cough	☐No	☐Yes	Shortness of Breath	☐No	☐Yes
Easy Bruising	☐No	☐Yes	Trouble urinating	☐No	☐Yes
Fever Blisters	☐No	☐Yes	Dry Eyes	☐No	☐Yes
Swollen feet/ankles	☐No	☐Yes	Fever/Chills	☐No	☐Yes
Problems swallowing	☐No	☐Yes			

Women Only:

Have you ever had a mammogram? ☐No ☐Yes If yes, when? _____
Do you do regular self breast exams? ☐No ☐Yes
Have you ever had breast lumps or discharge ☐No ☐Yes
Did you breast feed? ☐No ☐Yes
Bra Size _____
Have you had a C-Section ☐No ☐Yes

Signature: _____ **Date:** _____

Relationship to Patient: _____

Physician's Signature: _____ **Date:** _____ **Time:** _____

Carolinas HealthCare System

CMC Cosmetic and Plastic Surgery
Medical History

Patient Information or Sticker

Name:

DOB:

Medical Record #:

CMC Cosmetic and Plastic Surgery

1025 Morehead Medical Drive, Suite 200
Charlotte, NC 28204
Phone: 704-446-6810 Fax: 704-355-2467

PLEASE READ AND SIGN AT THE BOTTOM THAT YOU UNDERSTAND THE FOLLOWING:

Request for Treatment and Authorization

REQUEST FOR TREATMENT. The hospital maintains personnel and facilities to assist my physicians in providing me medical care, and I authorize the hospital to perform on me the care ordered by my physicians. I understand that I have the right to be informed by my physicians of the nature and purpose of any proposed operation or procedure and any available alternative methods of treatment, together with an explanations, which are the responsibility of my physicians to provide according to recognized standards of medical practice, and I acknowledge that the hospital and its personnel are not responsible for providing me this information. I choose to receive the services even if my insurance plan may not cover specific services, including the specific services rendered during the admission.

Insurance Assignment and Release

I certify that I have insurance coverage with: _____
(Name of Insurance Company (ies)

and assign directly to the Charlotte-Mecklenburg Hospital Authority (CHS). All insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance**. I authorize the use of my signature on all insurance submissions.
The above named facility may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

Notice of Privacy Practices

We are required by law to provide you with you Notice of Privacy Practices which explains how we use and disclose you health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

☐ I have been provided a copy of CHS' Notice of Privacy Practices.

Consent to Photograph

I understand that, as part of my care and treatment, or the care and treatment of another person for whom I have legal authority to consent, photographs will be taken prior to and following the procedure. I understand that this is part of the normal course of treatment and that these photographs will become part of the medical record. They will be kept confidential, except that they may be used for educational or scientific purposes. They will not be used for marketing purposes without my express consent.

☐ I do consent and agree to the terms regarding photographs

☐ I **do not** consent and agree to the terms regarding photographs

By signing below, I affirm that I have read and understand this form in its entirety and agree to be bound by all terms and conditions herein. If I am signing on behalf of another person, I affirm that I have the legal ability to consent on that person's behalf.

Patient's Name (Please Print): _____

Signature of Responsible Party: _____ Date: _____

Patient Information or Sticker

Name:

DOB:

Medical Record #:

CMC Cosmetic and Plastic Surgery
1025 Morehead Medical Drive, Suite 200 • Charlotte, NC 28204
Phone (704) 446-6810 • Fax (704) 355-2467

Financial Policy

In order for CMC Cosmetic and Plastic Surgery to continue providing quality care to its patients, it must receive payment for services rendered. PLEAS READ AND SIGN THIS FINANCIAL POLICY STATEMENT.

1. PAYMENT IS EXPECTED ON THE DAY OF YOUR OFFICE VISIT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. PLEASE COME PREPARED TO PAY FOR THE SERVICES YOU RECEIVE.

2. If your insurance is to pay for your visit, and you belong to an HMO policy, your primary care physician must authorize your visit before you can be seen. At the time of your visit, a copy of that authorization must be presented.

3. The charges made for your visit depend on the nature and the complexity of your problem. If you have any questions regarding the charges made for any visit, please direct them to the Central Billing Office at (704) 393-4808.

4. If you decide to have procedures preformed or services rendered which are non-covered procedures or services under your insurance policy, you agree to pay Carolinas Cosmetic and Plastic Surgery directly for those charges in advance.

5. There will be a $25.00 service charge on all returned checks.

I have read, understand and agree to abide by the Financial Policy of CMC Cosmetic and Plastic Surgery.

_____ _____

Signature of Patient or Guardian Date

_____

Print name of Patient

Patient Information or Sticker

Name:

DOB:

Medical Record #: