



COSMETIC & RECONSTRUCTIVE PLASTIC SURGERY
PATIENT INFORMATION

Date: _____

Patient Name: _____
Address: _____
City/State/Zip: _____
Drivers License #: _____

Phone: (hm) _____
(cell) _____
Email Address _____
Height: _____ ft _____ in Weight: _____ lbs

Birthdate: ____/____/____ Age: ____ Sex: Male or Female SSN: ____-____-____

Employer: _____ Phone #: _____
Occupation: _____

Emergency contact person and phone #: _____

REASON FOR INITIAL VISIT: _____

HOW DID YOU HEAR ABOUT US?

Self - Friend/Family - Phone Book - Magazine - Newspaper - Internet - Physician

If you found us on the internet, which website did you find us on?

BurgessPlasticSurgery.com - Plasticsurgery.org - Loveyourlook.com - Implantinfo.com
BreastImplants411.com - Google - Facebook or other: _____

Referring Doctor (name): _____
Address: _____
City/State/Zip: _____ Phone #: _____

INSURANCE INFORMATION:

SUBSCRIBER INFORMATION IS REQUIRED:

Relationship to patient: Self Spouse Child Other: _____

Subscriber Name: _____ Phone #: _____

Date of Birth: _____ Social Security Number: _____

Address: _____ City/State/Zip: _____

Primary Insurance: _____

Secondary Insurance: _____

Policy holders Name: _____

Policy holders name: _____

ID#: _____

ID#: _____

Group #: _____

Group #: _____

Address: _____

Address: _____

Phone #: _____

Phone #: _____

Signed: _____

Date: _____

Patient's signature/Guardian Signature

**COSMETIC & RECONSTRUCTIVE PLASTIC SURGERY
PATIENT INFORMATION**

Please list all surgeries, serious injuries, illnesses or diseases:

Type	Year	Surgeon/Physician	City/State
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any allergies: (example: Penicillin, sulfa, iodine, seafood, codeine, anesthesia, tape, eggs)

NO ALLERGIES _____

Food/Drug	Reaction
_____	_____
_____	_____
_____	_____

Current Medications: (please include herbal supplements or over-the-counter remedies)

Name of drug	Dose (mg)	How often taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical Conditions, which seem to run in your family:

_____	_____
_____	_____
_____	_____

Do you smoke? Yes No How much? _____

Do you use drugs: Yes No

Do you use alcohol? Yes No

If you use drugs or alcohol, what do you use and how often? _____

For women: Are you pregnant? Yes No Maybe

Have you had any diagnostic tests done? Where? When?

_____	X-rays	_____
_____	Mammogram	_____
_____	MRI	_____
_____	EMG	_____
_____	CT scan	_____
_____	Ultrasound	_____
_____	EKG/Stress test	_____
_____	Other	_____

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MEDICAL HISTORY:

Do you have any of the following medical problems? (please circle or add)

Constitutional: Recent unexpected weight loss, change in appetite, problems sleeping, fever, other.

Details: _____

Eyes: Dry eyes, glasses, contacts, vision changes, other.

Details: _____

Ears, Nose, Mouth, Throat: hearing aids, seasonal allergies, nosebleeds, difficulty breathing, previous injury, other.

Details: _____

Cardiovascular: high blood pressure, heart murmur (antibiotics prior to dental procedure), heart attack, irregular heart beat, mitral valve prolapse, other.

Details: _____

Respiratory: pneumonia, asthma, smoking, other.

Details: _____

Gastrointestinal, Pancreas, Liver: ulcers, bleeding, chronic diarrhea, abdominal pain, pancreatitis, hepatitis, liver disease, other.

Details: _____

Muskuloskeletal: carpal tunnel, joint replacement, muscle problems, broken bones, gout, other.

Details: _____

Renal: kidney problems, urine problems (urinary tract infections), bladder problems, other.

Details: _____

Skin/Breast: skin rash or problems, acne, accutane use, bronzing solution use, breast cancer/surgery, breast lumps, breast biopsies, breast radiation, lymphnode biopsy, other.

Details: _____

Neurological: seizure, head injury, stroke, neuropathy, nerve disease, headaches, migraines, fainting, other.

Details: _____

Endocrine: thyroid, diabetes, hormonal problems, other

Details: _____

Hematologic/Lymphatic: anemia, bleeding tendencies, bruise easily, coumadin use, DVT (deep venous thrombosis) or PE (pulmonary embolism), blood clots, phlebitis, blood disorder, other.

Details: _____

Allergic/Immunologic: anaphylactic reactions, HIV/AIDs, TB(tuberculosis), prolonged or persistent infections, other.

Details: _____

Other: fibromyalgia, depression, anxiety, stress, psychiatric problems, cancer, other.

Details: _____



PHOTO CONSENT

Please read and initial each point you wish to give your consent.

_____ I consent to have my photograph(s) taken to assist in my evaluation and medical treatment. Your photo is only of the area of concern and is for Dr. Burgess' evaluation only.

_____ I consent to the use of photographs taken of me, for the discussion with other trained Plastic Surgeons or of those practicing as Plastic Surgeons.

_____ I consent for the use of any record, illustration, photograph, or other imaging record created in my case, for use in examination, credentialing, and certifying purposes by The American Board of Plastic Surgery and Dr. Elisa Burgess. (Dr. Burgess feels strongly that board certification is important. Her practice is periodically evaluated and she may share your file, which includes your photographs, with the American Board of Plastic Surgery to continue her high standards of care.)

Patient/Guardian Signature

Date



FINANCIAL POLICY

COSMETIC CONSULTATION:

If Dr. Burgess agrees that you are a good candidate for surgery you will be presented with a cosmetic price quote at the end of your consultation. The **surgery fees for cosmetic procedures** include Dr. Burgess' fee, hospital operative room fees, anesthesiology fees, and implants/garments necessary for surgery. It will also include your pre-operative visit before surgery and office follow-up visits for one year following surgery. Quoted fees are honored for 90 days from the day of quotation. There is a \$500.00 non-refundable deposit due at the time of scheduling surgery that will be applied towards the surgeon's fee. *Please see price quote given at your consultation for more information.

INSURANCE CONSULTATION:

If your consultation involves **insurance**, please be prepared to pay the co-pay if applicable.

If insurance is involved in your visit: We will bill primary and secondary insurance companies. Please provide us with complete and accurate insurance information, as well as any changes of address, telephone number or employer. If your plan requires referral from your primary care physician, we ask that you phone your primary care physician prior to your appointment for the necessary authorization. Lack of referral could result in patient responsibility for service requested that day. Your insurance contract is between you and your insurance company. You are ultimately responsible for payment of your account. Note: If we are using insurance for your consultation your bill will be determined by your insurance company after being submitted by our office.

AGREEMENT TO PAY MEDICAL EXPENSES

1. Co-payments are collected at the time of your visits with the doctor. **Your insurance company will be billed by a billing service. When you have a personal balance, you will receive a monthly statement. Prompt payment of personal balances is appreciated. If you require special payment arrangements, please call the billing service**
2. **Medicare:** We are a participating clinic. We do accept assignment on Medicare claims.
3. **No Insurance:** Payment in full is required at the time of your appointment for all noninsured patients.
4. **Deposit:** We do require a non-refundable \$100.00 deposit for **in-office** procedures at the time the procedure is scheduled if insurance is not involved. (example of in-office procedure: lesion, mole, or cyst removal)

I authorize the release of any medical or other information to my medical insurance company necessary to process my claim, authorize services, or coordinate treatment. I request payment of government or insurance benefits directly to Elisa Burgess, M.D. I understand I am personally responsible for all medical expenses provided by Elisa A. Burgess, M.D., for medical care and treatment. I agree to pay all medical expenses within 30 days of the date I am billed for those expenses, unless other arrangements have been made with Dr. Burgess.

I have read, understand and agree to this financial policy.

Patient/Guardian Signature

Date



COSMETIC SURGERY POLICY

Please read each of the following:

1. Due to the fact that Dr. Burgess schedule is usually booked months in advance, final payment **MUST** be received 14 days before surgery or your surgery date will be forfeited. You may pay by check, Visa, MasterCard, Discover card, or American Express. We also offer financing through CareCredit. There is a \$500.00 non-refundable deposit due at the time of scheduling surgery that will be applied towards the surgeon's fee.
2. Surgery that is cancelled with less than 14 days notice will receive an **80%** refund of your total surgery costs.
3. After surgery, it is possible that additional related surgeries will be necessary. It is important to understand that the patient is responsible for operating room expenses, anesthesiologist's fees and possibly a percentage of the surgeon's fee.
4. Your arrival time for surgery is between 6:00 AM and 3:00 PM, therefore, the entire day should be allowed for surgery. Changes in the surgery schedule are impossible to predict and surgery times are estimates only, so your specific time may change. While we do our best to estimate as closely as possible, time estimates for arrival and discharge cannot be guaranteed and can change.
5. Lab work or other medical tests: There also **may** be additional separate fees charged for lab work, X-Rays, EKG, prescription medication, pathology reports, or compression garments. These are not included in the quoted fees and will be your responsibility.
6. **For in-office procedures:** We require that you pay a non-refundable \$100.00 deposit on our in-office procedures at the time of scheduling the actual procedure. If for some reason your procedure is postponed, the deposit will be credited to the rescheduled procedure date.

Printed Name

Patient/Guardian Signature

Date