COSMETIC & RECONSTRUCTIVE PLASTIC SURGERY
PATIENT INFORMATION

Date:__________________
Patient Name:______________________________ Phone: (hm)________________________
Preferred Name:______________________________ (cell)________________________
Permanent Address and/or PO Box:____
City/State/Zip:______________________________ Email Address________________________
Driver's License #:____________________________ Height:_____ft._____in Weight:______lbs.

Birthdate:_____/_____/_____ Age:_____ Sex: Male or Female SSN:______-_____-______
Marital Status: Single Married Life Partner Divorced Widowed

Employer:__________________________________ Phone #:___________________________
Occupation:_______________________________________

Emergency contact person and phone #:______________________________ Relationship:____________

REASON FOR INITIAL VISIT:____

HOW DID YOU HEAR ABOUT US?

Self - Friend/Family - Phone Book - Magazine - Internet - Physician - Insurance Company

If you found us on the internet, which website did you find us on?
BurgessPlasticSurgery.com - Plasticsurgery.org - Loveyourlook.com - RealSelf
Google - Facebook - Instagram 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

Elisa A. Burgess, M.D., F.A.C.S. - 503-699-6464 - 16865 Boones Ferry Road, Suite 101 - Lake Oswego, Oregon 97035
www.BurgessPlasticSurgery.com

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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)

Food/Drug	Reaction
________________________	_________________________
________________________	_________________________
________________________	_________________________

NO ALLERGIES ________ LATEX ALLERGY? Y or N TAPE ALLERGY? Y or N

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

Name of drug	Dose (mg)	How often taken
________________________	___________	_______________________
________________________	___________	_______________________
________________________	___________	_______________________
________________________	___________	_______________________
________________________	___________	_______________________

Do the following Medical Conditions run in your family? (please circle and state the relation).

High Blood Pressure _______________________
Stroke/Cardiovascular Disease ________________
Blood Clots (DVT) or Bleeding Disorders _________
____

Cancer (any type) ______________________
Asthma ______________________________
Diabetes _____________________________
Any other conditions______________________

Do you smoke cigarettes and/or marijuana? ___Yes___No How much?____________________
Have you ever smoked? ___Yes___No When did you stop?___________
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?________________________________

Do you have history of substance abuse or alcoholism? ___Yes ___No
If yes to either, please explain____

For women: Are you pregnant? ___Yes___No ___Maybe
Are you breastfeeding? ___Yes___No

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, chills, fatigue, headache, other.
Details:____

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

Opthamologic: Dry eyes, red eyes, discharge, wears glasses, wears contacts, other.
Details:____

Ears, Nose, Mouth, Throat: difficulty breathing, difficulty swallowing, previous injury, hearing aids, nosebleeds, sore throat, swollen glands, seasonal allergies, other.
Details:____

Endocrine: thyroid problem, diabetes, hormonal problems, other
Details:____

Respiratory: pneumonia, asthma, smoking, other.
Details:____

Breast: bloody nipple discharge, breast lump, breast pain, breast cancer surgery or biopsy, breast radiation, lymphnode biopsy, other.
Details:____

Cardiovascular: high blood pressure, heart murmur, heart attack, irregular heartbeat, mitral valve prolapse, chest pain at rest, chest pain with exertion, leg pain with walking, fluid accumulation in the legs, shortness of breath, other.
Details:____

Gastrointestinal, Pancreas, Liver: abdominal pain, change in bowel habits, constipation, diarrhea, exposure to hepatitis, heartburn/reflux, nausea, vomiting, ulcer, bleeding, pancreatitis, liver disease, motion sickness, history of post-op nausea or vomiting, other.
Details:____

Hematologic/Lymphatic: bruise easily, prolonged bleeding, recent transfusion, aspirin use, ibuprofen use, fish oil use, blood disorder, blood clot (DVT or PE), other.
Details:____

Genitourinary: blood in urine, difficulty urinating, painful urination, bladder problems, kidney problems, other.
Details.:____

Muskuloskeletal: carpal tunnel, joint replacement, muscle problems, gout, fibromyalgia, other.
Details:____

Skin: rash, acne, Accutane/Isotretinoin use, retin-a use, hydraquinone use, bronzing solution use, tanning bed use, keloid formation, skin cancer, severe sunburns, tattoos, permanent makeup, other.
Details:____

Neurological: seizure, head injury, stroke, hand/foot numbness, nerve disease, headaches, migraines, fainting, other.
Details:____

Psychiatric: depressed mood, anxiety, stressors, eating disorder, substance abuse, suicidal thoughts, seeing therapist, other.
Details:____

PHOTO 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, those practicing as Plastic Surgeons, or other medical professionals.

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.)

We proudly offer TouchMD technology in our office. With this cloud based system, patients can easily access this from their home, including drawings, photographs and educational information gathered during the consultation.

*None of the photos taken of you will be posted on any website or photobook of Dr. Elisa Burgess, unless a separate consent is given and signed by you, the patient.

____________________________________ __________________

Patient/Guardian Signature **Date**

FINANCIAL POLICY

COSMETIC CONSULTATION:

We require a $100 consultation fee for your first office visit with Dr. Burgess. This is a one-time fee and will apply toward any surgery or in-office procedure provided within one year of the consultation date. 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. **Appointments involving insurance**: 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 are appreciated. If you require special payment arrangements, please call the billing service, Service Plus at 503-284-8841.

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-$500 deposit for **in-office** cosmetic procedures at the time the procedure is scheduled if insurance is not involved. (example of in-office procedure: Ultherapy, CoolSculpting, Smartskin, etc.)

5. **Injectable procedures:** Payment for in office injectable procedures (i.e. Botox®, Juvederm®, Restylane®, Belotero®) will be collected at the time of treatment. Personal checks will not be accepted.

6. **Product sales:** For all purchased items in office i.e. skincare, sunscreens, etc., there will be no returns or refunds available.

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. If for any reason there is dispute of payment after treatment has been received, I the patient, waive my rights to privacy under the Health Insurance Portability and Accountability Act of 1996 guidelines. However, 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 and/or her billing service.

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

______________________________ ______________________

Patient/Guardian Signature **Date**

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COSMETIC 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 cost paid to Dr. Elisa Burgess.

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 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 cosmetic procedures**: We require that you pay a non-refundable $100-$500 deposit to schedule your in-office procedure. If for some reason your procedure is postponed, the deposit will be credited to the rescheduled procedure date. The remaining balance will be collected at the time of procedure. Personal checks will not be accepted.

____

Printed Name

____ ____________________

Patient/Guardian Signature **Date**

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