



Patient Information

Patient's Name _____
First Middle Initial Last

Address _____
Street & Apt# City State Zip

SS# _____ Birthdate _____

Race _____ Ethnicity _____ Preferred Language _____

Gender Male Female

Home phone: _____ Can we leave a message for you at home? Yes No

Phone: _____ Can we leave a message for you at work? Yes No

Cell phone: _____ Can we send you a text message? Yes No

Email address: _____ Can we send email to this address? Yes No

Preferred method of contact: Home Work Cell

Occupation: _____ Employer: _____

In case of emergency, contact: _____ Relationship to patient: _____

Home phone: _____ Work/Cell phone: _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____

Address: _____

Home phone: _____ Birth Date: _____ SS# _____

Primary Health Insurance

Name of Insurance Company: _____

Secondary Health Insurance

Name of Insurance Company: _____

All Commercial Insurance - Signature on File

I request that payment of authorized benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services.

Beneficiary Signature _____ Date _____

Medicare Patients Only - Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on her approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

Payment Policy

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Williams, or any dually accredited associate to bill my insurance company. I agree to pay all deductible, co pay, and non-covered service amounts. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Williams and myself.

Signature: _____ Date: _____



Notice of Privacy Policy

Patient's Name: _____

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may request a revised copy from the Privacy Officer.

Please list any persons (other than insurance carriers and healthcare professionals) who are authorized to receive protected health information about you:

No one

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all your questions regarding the contents of our Notice have been answered.

By signing this form, you acknowledge your right to revoke your consent in writing except to the extent that the practice has already made disclosures in reliance upon your prior consent.

Patient Signature
(Parent/Guardian Signature if patient is under the age of 18 years)

Date



General Records Release

JEFFREY S. WILLIAMS D.O., P.C.
Plastic & Reconstructive Surgery
Cosmetic Surgery
Hand & Micro Surgery
Pediatric Plastic Surgery

To: _____

I hereby authorize you to release to: **Dr. Jeffrey S. Williams, 575 Rivergate Ln. Ste. 205, Durango Co. 81301; Phone 970-259-5990 Fax 970-259-5934**; any information including the diagnosis and records of any treatment or examination rendered to me during the period from _____ to _____.

This records release is good until _____
Month Day Year

Date

Patient Signature

Witness

Print Name

Date of Birth



Medical History

Patient's Name _____
First Middle Initial Last

Birthdate: _____ Age: _____ Weight: _____ Height: _____ Reason for Visit: _____

Parent(s)/Guardians: _____ Referring Doctor: _____

Primary Care Provider _____ Cardiologist/Oncologist _____

How did you learn about our practice? Referring Provider Friend/family Internet/social media Phone book
 Promotional event (Which one?) _____ Radio Other: Please list _____

ALLERGIES: Environmental Allergies Latex Allergies Tape Allergies No Known Drug Allergies

List all **DRUG ALLERGIES** And Type of **REACTION**: _____

MEDICATIONS, VITAMINS, & SUPPLEMENTS: Attach list if more than five prescription medications

Rx:	Dose:	Reason:

Do you use any of the following? Mark all that apply: Insulin Coumadin Home Oxygen Aspirin or Ibuprofen Steroids

PREFERRED PHARMACY _____ **ADDRESS** _____

PERSONAL PAST MEDICAL HISTORY: Have you ever had any of the following?

	YES	NO		YES	NO		YES	NO
Abnormal Bleeding			Asthma			Attention Deficit		
Blood Clots			Fainting Spells			Atrial Fibrillation		
Heart Attack			Sleep Apnea			Cancer		
Coronary Stents			Thyroid Disease			Epilepsy/Seizure		
Heart Murmur			Tuberculosis			Anxiety/Depression		
Heart Disease			Hepatitis			Melanoma		
Anemia			Diabetes			Cystic Fibrosis		
High Blood Pressure			Kidney Disease			Melasma		
Stroke			HIV/AIDS			Lupus, Vitiligo, Porphyria		
Pacemaker			Cold Sores			Other		

Type of Cancer: _____ Other: _____ No major illness or hospitalizations

Have you been hospitalized in the past 6 months? No Yes: _____

Are your immunizations current? Yes No Unsure

Do you wear any of the following? (Mark all that apply) Contact lenses Eye glasses Hearing aids Dentures

PAST SURGERIES: No Past Surgeries

Date: _____ Type: _____ Hospital: _____ Surgeon: _____

Have you ever had a transfusion? No Yes

When? _____

Have you had any complications or bad reactions to anesthesia? Describe: _____



Medical History

Are you currently pregnant? Yes No Maybe

Number of Pregnancies: _____ Number of natural children: _____ Do you breastfeed? Yes No

Date of last mammogram: _____ Have you had your tubes tied? Yes No Have you had a hysterectomy? Yes No

FAMILY HISTORY: Have any blood relatives ever had any of the following?

	YES	NO		YES	NO		YES	NO
Breast Cancer			Tuberculosis			Thyroid disease		
Heart Disease			Stroke			AIDS/HIV		
Diabetes			Epilepsy			Cystic Fibrosis		
Abnormal Bleeding			Kidney Disease			Melanoma		
			Blood Clots			High Blood Pressure		

List any other serious illness not listed above: _____

Adopted or family history unknown

SOCIAL HISTORY: Adult Patients Only

Gender: _____ Occupation: _____ Marital Status: _____ Name of significant other: _____

Is a responsible adult available to assist during surgery recovery period? Yes No

Do you smoke? No Yes – What: Cigarettes Cigars How much? _____ packs/day or packs/week _____

Have you ever smoked? No Yes – Number of years smoked? _____ Date quit: _____

Are you aware that smoking increases the risk for surgical complications? Yes No

Do you drink alcohol? No Yes – How much? _____ drinks Daily 2-3 x per week Weekly Occasionally

Do you have a history of drinking to excess? No Yes – Date quit: _____

Do you use any recreational drugs? No Yes – List: _____

COSMETIC PATIENTS ONLY:

SKIN CARE

What products and regimen do you use on your face at home?

AM: _____

PM: _____

Is your skin: NORMAL OILY DRY COMBINATION

Do you wear sunscreen? YES NO

PREVIOUS INJECTIONS & LASER TREATMENTS

Have you had any of the following?

Botox / Xeomin / Dysport YES NO Treatment Date & Area: _____

Dermal Filler YES NO Treatment Date & Area: _____

Laser Treatments YES NO Treatment Date & Area: _____

Vein Treatments YES NO Treatment Date & Area: _____

OTHER _____