Patient Registration

Account No. (Office Use Only)

Referred By	Date

How did you hear about us?

Would you like to be added to our mailing list? ☐ Yes ☐ No Thanks

Patient

Full Name			
Social Security No.	D.O.B.	Age	☐ Male ☐ Female
Home Phone	Work Phone	Fax Phone	
Cell Phone	Preferred Phone	Pharmacy Phone	
Email Address		Drivers License No.	
Mailing Address			
City, State, Zip			

Employment (if minor, responsible parties)

Employed By	
Position	May we call you at work? ☐ Yes ☐ No
Address	

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name	Social Security No.
Spouse's Employer	Phone No.
Address	

In Case of Emergency

Name	Relationship	Phone No.
Name	Relationship	Phone No.

I understand that I am financially responsible for all charges. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, money orders and most major credit cards.

Signature ______________________ Date ______________

DPS 3005 (02/10)

SAM JEJURIKAR, MD

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INSURANCE AND FINANCIAL INFORMATION

Primary Insurance Company:____________________

Policy #: ____________________ Group #:____________________

Name of Policy Holder: ____________________ Relationship:____________________

Policy Holder Social Security Number:____________________ Date of Birth: ____________________

Secondary Insurance Company:____________________

Policy #: ____________________ Group #:____________________

Name of Policy Holder: ____________________ Relationship:____________________

PURPOSE OF VISIT

Is this visit for: Cosmetic ☐ Reconstructive ☐ Injury ☐ Work Injury ☐ Other ☐

Please specify purpose of visit: ____________________

____

Date of Injury:____________________ Type of Injury:____________________

FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services (including co-pays and deductibles) are due at the time services are rendered. We accept cash, checks and most major credit cards. This office will cooperate with individuals covered by insurance. We ask that you read your insurance policy and be fully aware of any limitations of the benefits provided. Realistically, you should look upon your insurance as a device that assists in reimbursement for medical expenses.

You must realize, however, that:

- Not all services are covered benefits in all contracts. Some insurance policies seemingly arbitrarily select certain services that will not be covered.
- All charges are your responsibility from the date services are rendered.
- Cosmetic procedures are not covered by insurance.

Signature:____________________ Date:____________________

Printed Name:____________________

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MEDICAL HISTORY

Name:______________________________ DOB:____________________

Age:____________________ Height:________ ft. ________ in. Weight:________ lbs.

Review of Systems (Check if you currently have any of the following systems):

CONSTITUTIONAL
- ☐ Fatigue/Weakness
- ☐ Fever
- ☐ Weight loss
- ☐ Weight gain

BREAST
- ☐ Breast discharge
- ☐ Breast lumps
- ☐ Breast pain

RESPIRATORY
- ☐ Cough
- ☐ Shortness of breath
- ☐ Spitting/Coughing blood
- ☐ Wheezing

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Heart murmur
- ☐ Shortness of breath with exertion
- ☐ Palpitations / Racing heart
- ☐ Ankle / foot / leg swelling

EYES
- ☐ Vision problems
- ☐ Blurred vision
- ☐ Vision loss
- ☐ Dry eyes

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty sleeping

NEUROLOGIC
- ☐ Dizziness
- ☐ Seizures
- ☐ Fainting / passing out

HEMATOLOGIC
- ☐ Anemia
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Swollen lymph nodes / glands

MUSCULOSKELETAL
- ☐ Back pain
- ☐ Bone fracture
- ☐ Joint pain
- ☐ Muscle pain
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Numbness
- ☐ Neck pain
- ☐ Shoulder pain

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Bloody stool
- ☐ Constipation
- ☐ Nausea
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Vomiting
- ☐ Reflux

SKIN
- ☐ Acne
- ☐ Changes in existing lesions / moles
- ☐ New skin lesions
- ☐ Shoulder grooving / bruising
- ☐ Itching
- ☐ Rash

Do you presently have or have you experienced the following (circle one)?

Y N - abnormal bleeding	Y N - blood clots	Y N - breast implants	Y N – cancer
Y N - COPD	Y N - diabetes	Y N - emphysema	Y N - epilepsy or seizures
Y N – heart attack	Y N – heart disease	Y N – hernia	Y N – high blood pressure
Y N – high cholesterol	Y N – kidney disease	Y N – lung disease	Y N – psychiatric disease
Y N – stroke	Y N – arthritis	Y N – abnormal breast biopsy	

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Are there any other medical conditions that we should know about? Please explain:

____

____

____

____

____

Please list all operations and/or hospitalizations and date:

HOSPITALIZATION / OPERATION	YEAR

HEALTH HABITS

Exercise:
- ☐ Sedentary (no exercise)
- ☐ Mild exercise (climb stairs, walk, golf)
- ☐ Occasional vigorous exercise (less than 4 times a week for 30 minutes)
- ☐ Regular vigorous exercise (Four times or more per week for 30 minutes)

Caffeine: ☐ None ☐ Coffee ☐ Tea ☐ Soda ____________ Number per day

Alcohol: ☐ Yes ☐ No What and how often? ______________________________

Tobacco: ☐ None ☐ Cigarettes ___packs per day ☐ Smokeless tobacco __________ how much
☐ Pipe / Cigar __________ how much
________ Number of years using tobacco products ________ Year quit using tobacco products

Drugs: Do you currently use recreational or street drugs? ☐ Yes ☐ No

DALLAS PLASTIC SURGERY INSTITUTE

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FAMILY HISTORY

Are there any significant medical problems in your family? If so, please list below:

FAMILY MEMBER	MEDICAL PROBLEM(S)

MEDICATION ALLERGIES

Are you allergic to any of the following (circle one)? Specify reaction below.

Y N – Aspirin ______ Y N – Codeine ______ Y N – Demerol ______
Y N – Hydrocodone ______ Y N – Morphine ______ Y N – Iodine ______
Y N – Shellfish ______ Y N – Penicillin ______ Y N – Erythromycin ______
Y N – Sulfa drugs ______ Y N – Tetracycline ______ Y N – Other antibiotics ______
Y N – Latex ______ Y N – Tape ______

Please list any other medications / items that cause allergic reactions:

MEDICATION / ITEM	ALLERGIC REACTION

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MEDICATIONS

Please list all medicines that you are currently taking, including prescription drugs, over-the-counter medications, vitamins and herbal supplements. Include medications taken only as needed (example nitroglycerin, pain medications).

MEDICATION	DOSE	DIRECTIONS	REASON FOR TAKING

PATIENT FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT

Your signature below forms a binding agreement between Dr. Sam Jejurikar (the provider of medical services) and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service.

MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform Dr. Jejurikar or his representative of the current address & phone number for the patient and responsible party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current by signing our data sheet.
- Pay any required copay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office. (When Dr. Jejurikar receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).

Returned Check Policy

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $25.00 Service Charge. Once notice is received of the returned check, Dr. Jejurikar or his representative will send a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $25.00 Check Service Charge.

Non-Payment on Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that Dr. Jejurikar or his representative has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and Attorney fees, and a collection fee will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print) ____

Patient Signature ___________________________________ Date ________________

Responsible Party Name (Please Print) ____

Responsible Party Signature ___________________________ Date ________________

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PHOTOGRAPHIC AUTHORIZATION AND RELEASE

By my signature below, I authorize Sam Jejurikar, MD, and his employees or agents to photograph me and/or make electronic recordings of me (hereafter referred to as photographic or electronic reproductions) in connection with the plastic surgery procedure(s) he has performed or may perform. This consent includes the taking of photographic or electronic reproductions of any part of my body.

I authorize the use of any such photographic or electronic reproductions of me for purposes of my treatment, education endeavors, and quality assurance review. I hereby grant permission for the use of any of my medical records including illustrations, photographs, or other imaging records created in my case, for use in examination, testing, credentialing and/or other imaging records created in my case, for the use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc. To the extent that I am not identifiable from such photographic or electronic reproductions, they may be used for any purpose, including but not limited to scientific or education purposes or publication in newspaper, magazines, and other public media as my be deemed appropriate by Sam Jejurikar, MD.

I understand that I may refuse to consent to the taking of any photographic or electronic reproductions that are not intrinsic to my operation or procedure without prejudice to my care.

Neither I, nor any member of my family, will be identified by name in any form of publication. Wherever possible, the photos will be cropped so as to show only the pertinent information, but not personally identifying information. I understand that in some circumstances, the photographs may portray features that will make my identity recognizable.

I have entered into this agreement in order to assist scientific treatment, educational, public relations and/or charitable goals and herby waive any right for compensation for these uses. I and my successors and assignees hereby waive any right for compensation for these uses. I and my successors and assignees hereby hold Sam Jejurikar, MD, his employees, and any other person participating in my case and their successors and assignees harmless against any claim for injury or compensations resulting from the activities authorized by this consent.

______________________________	______________________________
Patient Printed Name	Witness Printed Name
______________________________	______________________________
Patient Signature	Witness Signature
______________________________	______________________________
Date	Time