

Michael D. Manuel, M.D. / Jana K. Cole, M.D.

Plastic Surgeons of Alaska, LLC
Plastic & Reconstructive Surgery

2741 DeBarr Rd, #C-215
Anchorage, Alaska 99508

Referring Doctor: _____

| | | | | | |
|--|----------------|--------------------------|--------------------------|-------------|----|
| Thank you for choosing our office. In order to serve you properly, PLEASE PRINT the following information. | | | | | |
| Name: | | Nickname: | Today's date | | |
| Address: | | City/State | Zip | DL# & state | |
| AGE: | SSN: | Birthdate: | Marital Status: | Gender: | |
| Home Ph: | | May we contact you here? | May we leave a message ? | | |
| Work Ph/Ext : | | YES | NO | YES | NO |
| Cellphone: | | YES | NO | YES | NO |
| Pager: | | YES | NO | YES | NO |
| Fax: | | YES | NO | YES | NO |
| Email: | | YES | NO | YES | NO |
| Occupation: | | Employer: | | | |
| Address: | | | | | |
| Spouse's Name, Occupation and Employer | | | | | |
| Emergency Contact Name: | | | Relationship: | | |
| ER Contact Home Ph: | | ER Contact Work Ph: | | | |
| <u>If patient is a minor:</u> | Father's Name: | Work Phone | | | |
| Father's Employer: | | | | | |
| Mother's Name: | | Work Phone: | | | |
| Mother's Employer: | | | | | |

PAYMENT FOR OFFICE VISITS OR OFFICE PROCEDURES IS REQUIRED AT THE TIME OF THE APPOINTMENT. WHEN POSSIBLE AN ESTIMATE OF THE CHARGES INVOLVED WILL BE GIVEN AND YOU WILL BE PROVIDED A RECEIPT FOR FILING WITH YOUR INSURANCE.

| | | |
|--------------------------------|--------|-----------|
| Primary Insurance Co: | | |
| Insured Party: | ID No: | Group No: |
| Ins Company Address: | | |
| Secondary Insurance Co: | | |
| Secondary Insured Party: | ID No: | Group No: |
| Ins Company Address: | | |

PLEASE PROVIDE COPIES OF INSURANCE CARDS

OVER

MEDICAL INFORMATION

PATIENT NAME: _____

REASON FOR OFFICE VISIT TODAY (PLEASE BE SPECIFIC) _____

REFERRED BY (NAME OF PHYSICIAN OR FRIEND) _____

IF INJURED, DATE OF INJURY _____ **DID THIS OCCUR AT WORK?** _____

HAVE YOU SEEN DR. MANUEL OR DR. COLE BEFORE? _____

IF SO, WHEN? _____

NAME OF USUAL PHYSICIAN _____

PAST SURGERY _____

KNOWN MEDICAL PROBLEMS (IF NONE , WRITE NONE) _____

DO YOU SMOKE CIGARETTES OR USE TOBACCO PRODUCTS? YES() NO()

HAVE YOU BEEN TESTED FOR THE HIV (AIDS) VIRUS? YES() NO()

RESULTS _____ **DATE OF TEST** _____

TO YOUR KNOWLEDGE HAVE YOU BEEN EXPOSED TO HIV? YES() NO()

I HEREBY AUTHORIZE DR. MANUEL AND DR. COLE OR THE OFFICE STAFF TO TAKE AND MAINTAIN PRE & POST OPERATIVE PHOTOGRAPHS AS A PART OF MY MEDICAL CHART.

SIGNATURE OF PATIENT OR GUARDIAN _____ **DATE** _____

PATIENT NAME _____

DATE _____

Medication ALLERGIES: please check

_____ **I have no medication allergies.**

_____ **I have medication allergies. Please list and describe what happens:**

What medications do you take? (include aspirin, non prescription medications, vitamins and natural pathic medications)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Other:

ASSIGNMENT AND RELEASE

*I hereby irrevocably authorize my insurance company/ fund to pay benefits for services directly to Plastic Surgeons of Alaska, LLC. **if I have not paid in full myself.** Furthermore, **I understand that I am financially responsible for any amount not paid by my insurance company.** I also authorize Plastic Surgeons of Alaska, LLC to release any information required to process a claim, including but not limited to insurance companies, health care service plans, worker's compensation carriers and government services.*

PATIENT'S

SIGNATURE: _____

DATE _____

IF PATIENT IS A MINOR:

PARENT/GUARDIAN

SIGNATURE _____

DATE _____

RELATIONSHIP TO

MINOR _____

PRIVACY

I understand the Federal Government has placed restrictions on the exchange/release of patient medical information. In cooperation with these regulations and to facilitate better and more rapid exchange of information, I offer consent to the release of information to other treating physicians or health care providers, hospitals, my insurance company (or other payers). I understand this information may be exchanged via mail, fax, other electronic media (e-mail), telephone or orally. **All attempts will be made to keep this information STRICTLY confidential.**

PATIENT'S

SIGNATURE: _____

DATE _____

IF PATIENT IS A MINOR:

PARENT/GUARDIAN

SIGNATURE _____

DATE _____

RELATIONSHIP TO

MINOR _____