

KRYGER INSTITUTE OF PLASTIC SURGERY

Patient Information as of _____ 2010
(Please Print Legibly & Fill In/Correct All Fields)

Patient Name: _____ Birthdate: _____ SS#: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Email Address: _____ Restrictions for Contacting You: No Yes: _____

Gender: Male Female Drivers License #: _____

Marital Status: Single Separated Married to: _____ Other: _____

Patient's Employer: _____ Occupation: _____

Work Phone: _____ Ext: _____ May we call you at work: Yes No

Address: _____

Emergency Contact (*not* in your household) - Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Address: _____

Health Insurance Info: PPO POS HMO Workers Comp None Other

Primary Insurance: _____ ID#: _____ Group #: _____

Insured Party (if not self) – Name: _____ Birthdate: _____ SS#: _____

Relationship To Insured: Spouse Child Other _____ Copay: No Yes (Amount \$ _____)

Primary Care Physician Name (if HMO): _____ and Phone Number: _____

Secondary Insurance: _____ ID#: _____ Group #: _____

Insured Party (if not self) – Name: _____ Birthdate: _____ SS#: _____

Referral Source: Insurance Company ER Dr. _____ Patient: _____

Newspaper Magazine Website: DrKryger.com LoveYourLook.com Search Engine Result
 Other: _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Kryger to bill my insurance company, however I understand that not all fees may be covered by my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Kryger and myself.

Signature: _____

Date: _____

Kryger Institute of Plastic Surgery
Hand Patient Health History

Name: _____ **DOB:** _____ **Date:** _____

SOCIAL

Age: _____ Sex: M F Married: Y N Occupation: _____

[] Right Handed [] Left Handed Hobbies requiring use of Hands: _____

HABITS

Smoke: Y N Amount: _____ Caffeine Consumption: Y N Amount: _____

Alcohol: Y N Amount: _____ Daily Exercise: Y N Amount: _____

MEDICATIONS: List dose or number of pills per day

Prescription Drugs:	Dose:	Treatment for:	Non-Prescription (Vitamins, Herbs, etc.):
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Regular Aspirin Use: Y N Dosage & frequency: _____

NSA (Advil, Motrin, Ibuprofen): Y N Dosage & frequency: _____

Cortisone Injections Past Year: Y N Date(s) and injection location: _____

***Drug Allergy:** N Y -- List drug(s) and type of reaction: _____ [**Latex Allergy:** Y N **Tape Allergy:** Y N]

PERSONAL PAST HISTORY: Have you ever had:

Abnormal Bleeding: Y <input type="radio"/> N <input type="radio"/>	Asthma: Y <input type="radio"/> N <input type="radio"/>	Hypertension: Y <input type="radio"/> N <input type="radio"/>
Abnormal Clotting: Y <input type="radio"/> N <input type="radio"/>	Diabetes: Y <input type="radio"/> N <input type="radio"/>	Sleep Apnea: Y <input type="radio"/> N <input type="radio"/>
Acid Regurgitation: Y <input type="radio"/> N <input type="radio"/>	Cancer: Y <input type="radio"/> N <input type="radio"/>	Snoring: Y <input type="radio"/> N <input type="radio"/>
Anemia: Y <input type="radio"/> N <input type="radio"/>	Heart Attack: Y <input type="radio"/> N <input type="radio"/>	Weight Change past 12 Mo.: Y <input type="radio"/> N <input type="radio"/>
Angina: Y <input type="radio"/> N <input type="radio"/>	Hepatitis: Y <input type="radio"/> N <input type="radio"/>	Other Serious Illness: Y <input type="radio"/> N <input type="radio"/>
Psychiatric Treatment: Y <input type="radio"/> N <input type="radio"/>	Infections: Y <input type="radio"/> N <input type="radio"/>	Scarring Problems: Y <input type="radio"/> N <input type="radio"/>

Please describe questions with a "Yes" answer: _____

Previous Surgeries:	Surgery Date:	Surgeon:
_____	_____	_____
_____	_____	_____

FAMILY HISTORY: Have any **blood relatives** ever had the following problems:

Abnormal Bleeding: Y <input type="radio"/> N <input type="radio"/>	Coronary Surgery: Y <input type="radio"/> N <input type="radio"/>	Kidney Disease: Y <input type="radio"/> N <input type="radio"/>
Abnormal Clotting: Y <input type="radio"/> N <input type="radio"/>	Diabetes: Y <input type="radio"/> N <input type="radio"/>	Tuberculosis: Y <input type="radio"/> N <input type="radio"/>
Anesthetic Problems: Y <input type="radio"/> N <input type="radio"/>	Heart Attack: Y <input type="radio"/> N <input type="radio"/>	Other Serious Illness: Y <input type="radio"/> N <input type="radio"/>
Cancer: Y <input type="radio"/> N <input type="radio"/>	Hypertension: Y <input type="radio"/> N <input type="radio"/>	

Please describe questions with a "Yes" answer: _____

Primary Care Physician: _____ **Phone Number:** _____

Referring Physician: _____ **Phone Number:** _____

_____ M.D.



**PATIENT CONSENT FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Reconstructive Surgery

- Microsurgery*
- Post-mastectomy*
- Abdominal wall*
- Lower extremity*
- Facial fractures*
- Skin cancer*
- Wounds*
- Pediatric*

Hand Surgery

- Fractures*
- Wrist injuries*
- Nerve compression*

Aesthetic Surgery

- Face*
- Breast*
- Body contouring*
- Non-surgical procedures*

- I hereby give my consent for The Kryger Institute of Plastic Surgery, AMC to use and disclose protected health information about me to carry out treatment, payment and healthcare operations (TPO). The Kryger Institute's Notice of Privacy Practices provides a more complete description of such uses and disclosures.
- I have the right to review the Notice of Privacy Practices prior to signing this consent. The Kryger Institute reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Kryger Institute of Plastic Surgery.
- With this consent, The Kryger Institute of Plastic Surgery, AMC and staff may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carry out TPO such as appointment reminders, insurance items and any calls pertaining to my clinical care.
- With this consent, The Kryger Institute and Staff may mail to my home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.
- With this consent, The Kryger Institute and Staff may e-mail to my home or other alternative location any items that the practice in carrying out TPO, such as appointment reminder cards, patient statements.
- With this consent physician peers may review my office and operating room charts for operative consent and completeness of chart.
- I have the right to request that The Kryger Institute restrict how it uses or discloses my information to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.
- By signing this form, I have consented to The Kryger Institute of Plastic Surgery, AMC's use and disclosure of my protected information to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance **upon** my prior consent. If I do not sign this consent, or later revoke it, The Kryger Institute may decline to provide treatment to me.

Patient Signature (or person authorized): _____

Printed Name of Patient: _____ Date: _____