SMITH COSMETIC SURGERY CENTER

The Smith Center
1701 S. SHEPHERD, SUITE D
Houston, TX 77019
Tel 713 795 0600 Fax 713 795 0862
www.KevinSmithMD.com

REGISTRATION
(Please Print)

Date: _____ Home Phone: _____ Cell Phone: _____

PATIENT INFORMATION

Name: _____ Social Security #: _____
Last First Middle Initial

Address: E-mail: _____

_____ ___ Married ___Widowed ___Divorced
Street Unit

_____ ___ Separated ___Single ___Minor
City State Zip

Sex: ____M ____F Age:_____ Birthdate: _____/_____/_____

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ Phone: _____

In Case of Emergency who should be notified? _____ Phone: _____

PRIMARY INSURANCE

Person Responsible for Account: _____
Last First Middle Initial

Relation to Patient: _____ Birthdate: _____/_____/_____ Social Security# _____

Address:(if different from patient)_____
Street Unit #

_____ Phone: _____
City State Zip

Person Responsible Employed By _____ Occupation: _____

Business Address: _____ Bus Phone _____

Insurance Company: _____ ID# _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ____ Yes ____ No

Subscriber Name_____ Birthdate _____ Relation to Patient _____

Address_____ Phone_____
Street Unit #

_____ Soc Sec# _____
City State Zip

Subscriber Employed By: _____ Bus Phone _____

Insurance Company:_____ ID # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependant(s), have insurance coverage with _____ and assign directly to Dr. Kevin Smith all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my healthcare information and may disclose such information to the above listed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Printed Name of above Signature Date

Patients Medical History

Date: _____

NAME:	AGE:
Your Current Physician(s):	
Address:	PHONE NUMBER: ( )
Reason for Visit:	
List All Surgeries/Hospitalizations And the Date of Occurrence:	
List Any Serious Illnesses, Injuries, and/or Accidents:	

Do you have or have you had any of the following: (circle if yes and list date of occurrence)

AIDS/HIV+	NO	YES	HAY FEVER/ALLERGIES	NO	**YES**
ARTHRITIS	NO	YES	HEADACHES/MIGRAINE	NO	**YES**
ASTHMA	NO	YES	HEART TROUBLE	NO	**YES**
BRONCHITIS	NO	YES	HEPATITIS (A. B. C) please circle	NO	**YES**
CANCER	NO	YES	HIGH BLOOD PRESSURE	NO	**YES**
DEPRESSION	NO	YES	KIDNEY PROBLEMS	NO	**YES**
DIABETIS	NO	YES	PNEUMONIA	NO	**YES**
DIZZINESS/VERTIGO	NO	YES	SINUS PROBLEMS/INFECTION	NO	**YES**
EAR INFECTION	NO	YES	STROKE	NO	**YES**
EPILEPSY/SEIZURE	NO	YES	TONSILLITIS	NO	**YES**
FACIAL PAIN	NO	YES	TUBERCULOSIS	NO	**YES**
FEVER BLISTERS	NO	YES	ULCERS	NO	**YES**
GOITER/THYROID	**NO**	**YES**			

DO YOU SMOKE?	HOW MUCH?	HOW MANY YEARS?	NO	YES
DO YOU DRINK ALCOHOL OR BEER?		HOW MUCH/ MANY YEARS?	NO	YES
DO YOU USE RECREATIONAL DRUGS?			NO	YES
DESCRIBE:				
DO YOU HAVE BLEEDING OR BRUISING PROBLEMS?			NO	YES
DO YOU HAVE TROUBLE WITH SCARRING?			NO	YES
DO YOU HAVE ANY HISTORY OF PROBLEMS WITH ANESTHESIA?			NO	YES

PLEASE CIRCLE AND LIST THE NAME OF THE MEDICATIONS YOU ARE PRESENTLY TAKING OR HAVE TAKEN WITHIN THE LAST MONTH.

AFRIN/NASAL SPRAYS	BIRTH CONTROLL PILLS	HORMONES	THYROID MEDICATION
ANACIN	BLOOD PRESSURE MEDICINE	IBUPROFIN/ADVIL/MOTRIN	TRANQUILIZERS
ANTIBIOTICS	BUFFERIN	INSULIN	VITAMIN E
ARTHRITIS	CORTISONE	SLEEPING PILLS	ACCUTANE
ASPIRIN	DILANTIN	STEROIDS	COUMADIN

LIST ALL OTHER MEDICATIONS:

LIST ALL DRUG ALLERGIES:

We are glad you have chosen our medical practice for your health concerns. Please let us know how you heard of us.

- Primary Care Physician: Name: _____
  Address: _____
  Phone: ( ) _____
- Friend: Name: _____ Phone:( ) _____
- Newspaper/Magazine: Name of Publication: _____
- Radio/Television/Interview/Advertisement. Show Name: _____
- Other. Please Specify: _____

Thank You.

Patient Financial Responsibility and Consent

PATIENT NAME: _____

Please read each section carefully, then sign and date where requested. Signature must be by patient or person authorized to give consent for the patient. Parent or Guardian must sign if patient is a minor.

I do hereby transfer all interest in and title to my reimbursement monies from my insurance company to Kevin R Smith M.D. I also authorize the release of any medical or other information necessary to process my insurance claims by mail or fax.

SIGNATURE: _____ DATE: _____

I realize that I am fully responsible for the entire balance of my account with Dr. Kevin Smith. I understand that my insurance company's reimbursement for services rendered may not cover the full charges that I am responsible for any unpaid balance. I understand that I may be required to pay for the entire balance if the insurance company has not paid within 90 days of claims submission. I understand that Dr. Kevin R Smith collects all applicable co-pays, estimated co-insurance and deductibles at the time of an office visit or prior to a procedure, although this in no way excludes me from further financial responsibility.

SIGNATURE: _____ DATE: _____

I am aware that all charges for cosmetic surgery, or what may be considered elective surgery, are payable in advance.

SIGNATURE: _____ DATE: _____

RELEASE OF PHOTOGRAPHS

I hereby give permission to Kevin R. Smith, M.D. to take photographs to enhance my medical record. I also agree that these photographs will remain the property of Dr. Smith. I further authorize the use of such photographs for teaching purposes or to illustrate scientific papers, books and/or lectures.

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

Smith Center

Consent to Use and Disclose Protected Health Information

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION
Your protected health information will be used by Smith Cosmetic Surgery Center or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

THE NOTICE OF PRIVACY PRACTICES
Smith Cosmetic Surgery Center is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you with information on how you may get access to this information. These policies and practices are defined in the "notice of Privacy Policies and Practices" brochure provided to you. PLEASE REVIEW IT CAREFULLY.

YOU MAY PLACE RESTRICTIONS ON THE USE OF OR DISCLOSURE OF YOUR HEALTH INFORMATION
You may request a restriction on the use or disclosure of your protected health information. However, Smith Cosmetic Surgery Center may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative if you would like additional information or clarification.

It is a violation of the federal privacy standards if Smith Cosmetic Surgery Center agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have question after reviewing the Notice of Privacy brochure, please consult with a practice representative or a privacy officer at the location and contact information in the back of the brochure.

YOU MAY REVOKE THIS CONSENT AT ANY TIME
You may revoke this consent at anytime however, Smith Cosmetic Surgery Center requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of your request.

CHANGES TO PRIVACY PRACTICES
Smith Cosmetic Surgery Center reserves the right to change or modify the privacy practices outlined in the "Notice of Privacy Policies and Practices" brochure. Smith Cosmetic Surgery Center will notify you of any changes of privacy practices either by mail, at your next appointment, or any other approved method that you request.

SIGNATURE
I have reviewed this consent form, received the brochure entitled "Notice of Privacy Policies and Practices" and give my permission to Smith Cosmetic Surgery Center to use and disclose my health information in accordance with this consent and the notice provided.

_____ _____
Name of Patient (print or type) Signature of Patient/Date

_____ _____
Patient Representative (print or type) Signature of Representative/Date

_____
Relationship of Patient Representative to Patient

Kevin R. Smith M.D., P.A.

1701 S. Shepherd, Suite D

Houston, TX 77019

Phone : (713) 795.0600

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

COPAY IS DUE AT THE TIME OF YOUR APPOINTMENT.

We now offer the following payment options:

____ Payment by cash

____ Payment by check

____ Payment by credit card (VISA, AMEX, MC, DISCOVER)

____ Automatic monthly billing to your Visa or Master Card (****for procedures only***)

____ Guarantee any amount not covered by insurance with Visa or Master Card

Please check your form of payment, sign below and return it with your paper work before treatment.

Office charges may include:

$200.00 New Cosmetic Consultation Fee

$200.00 Self-Pay Office Visit

Specialist Office Visit Co Pay

30% Deposit Required to book surgery

Thank You.

_____

Please print your name here and sign below

X _____ Date:_____

Signature

Smith Center
1701 S. Shepherd Dr. Ste D
Houston, TX 77019
Phone: (713)795-0600
Fax: (713)795-0862

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME _____ **DATE** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Smith Center may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Smith Center has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Smith Center will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Smith Center to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Smith Center has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

Relationship to Patient if signed by another party _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Smith Center, 1701 S. Shepherd Dr. Ste D, Houston, TX 77019, Ph: (713)795-0600, Fax: (713)795-0862.

FORM Us

SMITH COSMETIC SURGERY CENTER

Smith Cosmetic Surgery Center

Tel 713 795 0600 Fax 713 795 0862
www.smithctr.com

Headache Questionnaire

PATIENT'S NAME: _____ **DATE:** _____

Please answer the following questions **if** you suffer from headaches

How long have you suffered from headaches? _____ weeks/months/years

How often do you have headaches?
1-2 monthly 1-3 weekly 3-5 weekly Daily

Please circle the location of your headaches:
Eyes: right/left Temples: right/left Back of Head Top of Head Cheeks: right/left Forehead: right/left

Please circle the number that represents the **minimum, maximum** and **average** severity of your pain:
Mild 1 2 3 4 5 6 7 8 9 10 Severe

Circle all the types of pain you experience:
Constant Pounding Dull Sharp Pressure

What time of day do you usually get headaches? Morning Afternoon Night There is no pattern

Do you have allergies? _____ Seasonal Only? _____ Year Round? _____

Are your headaches seasonal? _____ Season(s): _____

Are your headaches associated with:
Menstrual cycle Allergy/Sinus problems Cold/Flu Weather Changes Altitude Changes

Please list all triggers that cause your headaches: _____

Do you have any of these symptoms with your headache?
Nausea Vomiting Light Sensitivity See Flashing Lights Blurred Vision Slurred Speech Dizziness
Numbness Tingling of Arms or Legs Ringing in Ears Other: _____

The definition of sinusitis is: fever, green nasal drainage and facial pain requiring antibiotics to cure.

How many sinus infections do you get per year? _____

Do you have high blood pressure? _____ Treatment: _____

Do you have a family history of headaches? _____ Relationship: _____

Please list any nasal or facial trauma you have experienced: _____
_____
_____

Do you have difficulty breathing through your nose? _____
Right-sided blockage Left-sided blockage Both sides blocked

Are you congested: More than 50% of the time Less than 50% of the time About 50% of the time
Most Mornings Most Nights

Have you been diagnosed with any of the following?
Deviated Nasal Septum _____
Allergic Rhinitis _____
Nasal/Sinus Polyps _____
Facial Fracture _____

Have you seen a neurologist or other specialist about your headaches? _____

Please list their names and addresses: _____
_____
_____

Please list any diagnostic tests and approximate dates performed (CT Scans, MRI, etc): _____
_____
_____

List all past and present headache medications:
Past: _____
Present: _____

List all past and current allergy medications:
Past: _____
Current: _____

What medications or treatments make your headaches better? _____
_____

How many days of work do you miss yearly due to headaches? _____

How many visits to the emergency room do you make yearly as a result of headaches? _____

What types of therapy (yoga, chiropractor, stimulation units, etc.) have you attempted to resolve your headaches?
Acupuncture _____
Botox Injections _____
Chiropractor _____
Herbs _____
Electrical Stimulation Units _____
Relaxation/Yoga _____

How much do you estimate your headaches cost you? *Consider medications, medical office visits, hospitalization, surgery, labs, tests, scans, etc. $_____ per month $_____ per year