PLASTIC SURGERY
NORTHWEST

Demographics

First Name	Last Name	MI	AGE	DOB
Other Names Used (past or present)		Preferred Language		SSN
Reason for visit? (List cause injury if applicable.)		Primary Care Provider		
Marital Status	Race		Ethnicity	
Spouses First Name	Last Name	MI	DOB	SSN
Address	City	State	Zip	
Occupation	Employer	Email		
Check Contact Preference ☐ Home Phone	☐ Work Phone	☐ Cell Phone Text Message ok? Yes No		
Emergency Contact	Relationship to Patient	Primary Phone	Secondary Phone	
How did you hear about us? (Website, Magazine, RealSelf, Google, Friend, Other)				
Primary Health Insurance				
ID #	Group #			
Referral Required?	Copay			
Claim Number (L&I or auto insurance)	Date of Injury			
Insured Name	DOB	SSN	Employer	
Secondary Health Insurance				
ID #	Group #			
Insured Name	DOB	SSN	Employer	

Financial Information

Please bring your insurance card(s) with you to every appointment. It is the patient/guarantor's responsibility to know and understand their insurance benefits, covered services, and financial responsibilities. Our billing staff members are available from 8:00AM – 5:00PM Monday through Friday and can be reached by calling 509-838-1010.

Plastic Surgery Northwest accepts the following forms of payment:
Visa, MasterCard, CareCredit, cash and cashier's checks.

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Health History

Height	Weight

List any major medical conditions you have been diagnosed with (i.e. COPD, diabetes, Asthma etc.)

Family History: Please list any major medical problems of your immediate family.
(If you are seeing us for cancer please list all family members with your type of cancer)

Do you have or have you had any of the following (circle for each, give date occurred if "yes")

Aids/HIV	No	Yes	Facial Pain/Cold Sores	No	Yes	High Blood Pressure	No	Yes
Arthritis	No	Yes	Seizures/Fainting	No	Yes	Kidney Problems	No	Yes
Asthma/COPD	No	Yes	Weakness/Paralysis	No	Yes	Sinus Problems/Infections	No	Yes
Bronchitis/Pneumonia	No	Yes	Thyroid Problems	No	Yes	DVT/Blood Clots	No	Yes
Cancer	No	Yes	Hay Fever/Allergies	No	Yes	Indigestion/Nausea	No	Yes
Depression/Anxiety	No	Yes	Headaches/Migraines	No	Yes	Heartburn/GERD	No	Yes
Diabetes	No	Yes	Heart Trouble/Attack	No	Yes	Auto Immune Disease	No	Yes
Dizziness/Vertigo	No	Yes	EKG Abnormalities	No	Yes	Hepatitis	No	Yes
Stroke	No	Yes	Chest Pain	No	Yes	Chronic Pain	No	Yes

List all surgeries (hospitalization and the date of occurrence):

Do you smoke or use **any** nicotine products (including e-cigs, gum, patch etc.)	If yes, how much?	Date Quit:	Do you drink Alcohol?	If yes, how much? How often?

Have you ever been pregnant?	Yes No	Who do you currently live with?
Have you ever, or do you plan on breast feeding?	Yes No	
Is there any chance you are currently pregnant?	Yes No	

Do you use recreational drugs?	Yes	No	Describe:
Do you have bleeding or bruising problems?	Yes	No	Describe:
Do you have problems with scarring?	Yes	No	Describe:
Do you or your family have a history of problems with anesthesia?	Yes	No	Describe:
Have you ever been on steroids?	Yes	No	Describe:

We will electronically send any applicable prescriptions (except narcotics) Pharmacy: Location:	List ALL drug and/or latex allergies:

List the name of all medications you are presently taking or have taken within the last month. Include name of drug, dosage and frequency (**use back if needed.**):

Is there anything else you would like to tell your physician?

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Release of Information

I_____, authorize the capture, disclosure, and use of photographs, video and accompanying protected health information related to my healthcare services at Plastic Surgery Northwest. I understand that my photo will be taken and placed in my permanent medical record. I understand that such photographs shall be retained for the purpose of public education, publication in visual media (including medical journals, textbooks, and presentations), PSNW website and/or social media and advertising.

I authorize Plastic Surgery Northwest, LLC to use and/or disclose the above-named individual's protected health information, including any and all documents containing information regarding any amendment of such information in the medical records as described below for the purpose of continuity of care for the period of _____ to _____.

Records to be disclosed:

- Comprehensive overview of chart from date:_____ to _____.
- Images
- Other (specify type (required) – e.g. discharge summary, operative reports, billing records, lab reports.)

_____

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so, it will not affect any actions taken prior to my revocation. If I do not revoke this authorization, it will expire 10 years from the date written below.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or federal Health Insurance Portability and Accountability Act of 1996 ("HIPPA").

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy information to be used or disclosed, as provided by federal and state law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by applicable confidentiality rules. If I have questions about the use or disclosure of my health information, I can contact Plastic Surgery Northwest at 509-838-1010.

*Please initial the below referenced information you wish to authorize.

_____I hereby give my consent for Plastic Surgery Northwest Physicians or staff to leave information regarding my treatment, results, appointment information, or recommendations on my voicemail at the phone numbers I have provided.

_____I hereby give my permission for Plastic Surgery Northwest Physicians or staff to phone me at my work.

_____I hereby give my permission for Plastic Surgery Northwest Physicians or staff to discuss my billing, appointment, and caretaking information with the person/persons listed below:

Name_____Relationship to Patient_____

Minors: A minor patient's signature is require in order to release the following information (1) conditions relating to the minor's reproductive care, (2) sexually transmitted diseases (if age 14 and older), (3) alcohol and/or drug abuse and mental health conditions (if age 13 and older.)

I certify that I have read the about Authorization and Release and fully understand its terms.

_____ _____

Patient Signature *Date*