
## PATIENT REGISTRATION INFORMATION

**Date:**_____ **Name:**_____**Sex:**_____
**Last** **First** **Middle**
**Address:**_____ **Martial Status**_____

**City:**_____ **State:**_____ **Zip Code:**_____**E-mail:**_____

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

**Birthdate:** _____**Age:**_____ **Social Security #:**_____

**Race:**_____ **Ethnicity:**_____

**Pharmacy:** _____ **Pharmacy address:** _____

**Employer:**_____ **Occupation:**_____

**Emp. Address:**_____ **Emp. Phone:**_____

**Primary Care Physician:**_____ **Address:**_____

**I prefer to be contacted by:** ☐ **Home Phone** ☐ **Cell Phone** ☐**Email** ☐ **Other** _____

**May we leave a voice message regarding your medical information?** ☐**Yes** ☐**No**

**I authorize you to discuss any medical information regarding me with:**_____

**How did you hear about us?**☐ **Yellow Pages,** ☐ **Internet**_____**,** ☐ **Physician**_____

☐ **Friend or relative**_____**,** ☐ **Seminar or lecture**_____

**Emergency Contact:**_____**Phone:**_____

## BILLING INFORMATION

**Person Responsible for Account:**_____**SS#**_____

**Address:**_____**Date of Birth**_____

**City:**_____ **State:**_____ **Zip Code:**_____**Phone:**_____

**Primary Insurance:**_____ **ID #:**_____

**Group #:**_____ **Ins. Phone:**_____

**Subscriber:**_____ **Relation to Patient:**_____

**Secondary Insurance:**_____ **ID#:**_____

**Group #:**_____ **Ins. Phone:**_____

**Subscriber:**_____ **Relation to Patient:**_____

## PHOTO CONSENT

I consent to be photographed before, during, and after treatment. These photographs will be the property of Jennifer Boll, M.D.

Patient: _____ Date: _____

I consent for these photos to be used on the website and/or for marketing purposes. You have the right to review these photos prior to publishing and/or have them removed anytime.

Patient: _____ Date: _____

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**PATIENT HEALTH QUESTIONNAIRE**

**Do you have or have you ever had the following?**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Congestive Heart Failure | ☐ | ☐ | Stroke | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | Fainting/Dizziness | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Seizure/Epilepsy | ☐ | ☐ |
| Arrhythmias | ☐ | ☐ | | | |
| Abnormal EKG | ☐ | ☐ | Alcoholism | ☐ | ☐ |
| Other Heart Problems | ☐ | ☐ | Liver Cirrhosis | ☐ | ☐ |
| Atherosclerosis | ☐ | ☐ | Jaundice | ☐ | ☐ |
| Poor leg circulation | ☐ | ☐ | Hepatitis, what type?_____ | ☐ | ☐ |
| Easy bleeding/bruising | ☐ | ☐ | HIV/AIDS | ☐ | ☐ |
| Chest Pain | ☐ | ☐ | | | |
| Peripheral Vascular Disease | ☐ | ☐ | Autoimmune Disease | ☐ | ☐ |
| High Cholesterol | ☐ | ☐ | Skin Disorder, eczema, psoriasis | ☐ | ☐ |
| | | | Cold Sores, Herpes Simplex Virus | ☐ | ☐ |
| Asthma | ☐ | ☐ | Facial weakness, Bell's Palsy | ☐ | ☐ |
| COPD | ☐ | ☐ | | | |
| Emphysema | ☐ | ☐ | Arthritis | ☐ | ☐ |
| Shortness of Breath | ☐ | ☐ | | | |
| Chronic Cough | ☐ | ☐ | Cancer of any kind, type? _____ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Hyperthyroidism | ☐ | ☐ |
| Gastrointestinal Problems | ☐ | ☐ | Hypothyroidism | ☐ | ☐ |
| | | | Recent weight gain/loss, how much? _____ | | |

Do you have any other medical conditions not listed above?

_____

_____

Date of last physical exam? _____ Doctor who performed it? _____

Have you had any previous surgeries? Please describe and date.

_____

_____

_____

_____

Are you allergic to any drugs or medications?

_____

_____

_____

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Are you allergic to tape adhesive? Latex?_____

Are you allergic to iodine or shellfish? _____

Are you currently taking any medications? Dosage? Include birth control pills, hormones, vitamins, and herbal medications.

_____

_____

_____

_____

Do you take aspirin or any anti-inflammatory agents such as Advil, Motrin, Aleve, . . .etc. _____

Do you take any blood thinners or anticoagulants? _____

Have you ever had chemotherapy or radiation? _____

List all genetic disorders / family medical problems:_____

Current or past smoker? How many packs/day? How many years?_____

Do you consume alcohol regularly? How much per day?_____

Do you use “recreational” drugs? ☐ yes ☐no. If yes, ☐ marijuana, ☐ cocaine, ☐ meth, ☐ heroin, ☐ other _____

Are you or could you be pregnant?_____

If you are a new mother, are you currently breast feeding?_____

Do you or have you ever used Accutane? When last used?_____

What is the most you have ever weighed and when? _____

Please list reason for seeking plastic surgery consult_____

Are there any other areas you would like the doctor or staff to address?

☐ Improve skin ☐ Wrinkles ☐Forehead or brows ☐Eyes ☐Breasts ☐Chin ☐Cheeks ☐Loose Skin

☐Lips ☐Neck ☐Ears ☐Improve a scar ☐Removal of skin lesion ☐Botox ☐Abdomen

How long have you considered surgical correction?_____

Have you consulted other doctors about this? _____. If yes, how many? _____

## NOTICE OF PRIVACY PRACTICES

I have been given a copy of the Notice of Privacy Practices for the office of Dr. Jennifer E. Boll, M.D.

Patient:_____Date:_____

# Patient Financial Responsibilities Statement

Thank you for choosing Dr. Boll as your health care provider. We are committed to providing you with quality health care. The following is a statement of our financial policy which we require you to read and sign prior to any treatment.

## Insurance

All patients must complete our patient information and insurance form before being seen by the doctor.
All co-pays and patient responsible charges are due at time of service. If your insurance applies any of your charge to your annual deductible or coinsurance, that portion is due and payable by the patient upon receipt of your bill. It is the patient's responsibility to know their coverage. We will bill primary and secondary insurance. We do not do third party insurance billing. If your account is not paid in full within 120 days, it will be turned over to a collection agency for further processing. No additional appointments will be made for delinquent accounts until brought current.

By signing this below I hereby instruct and direct my insurance company to pay Dr. Boll directly for the professional and medical expense benefits allowed and otherwise payable for me under my insurance plan. This is a direct assignment of my benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said debt. I also authorize the release of information pertinent to my case to any insurance company adjuster or attorney involved in this case.

Non-covered services: Please be aware that some and perhaps all of the services you receive may be non-covered or not considered medically necessary by your insurance. You are responsible for and will be billed for these services.

## Cosmetic

All patients must complete our patient information and health form before seeing the doctor.
Consultation fee is $50 and will be applied to any surgery that is scheduled. A written quote will be given to you on the day of your consultation. This quote will include surgical, anesthesia, and operating room fees. Twenty five percent of the surgical fee will be collected at time of scheduling. This fee is non-refundable if surgery is cancelled or rescheduled within 2 weeks of surgery. If you have questions about this ask a staff member. The balance of the surgical fee is due 2 weeks prior to surgery. We accept cash, check, credit cards, cashier's checks, and Care Credit.

Surgical fees will change periodically. Fee quotes will be honored for 6 months from the date of quote.

Revisionary surgery is not commonly needed, however if you desire a revision, Dr. Boll will discuss this with you. You will be responsible for prevailing fees of the operating room, anesthesia, and the surgeon fees.

Additional out of pocket cost may include preoperative testing, labs, mammograms, chest x-rays and/or medications.

**In the situation of a dispute of financial charges, your right to privacy under the HIPAA act is waived until the dispute is resolved. This treatment includes our right to discuss your treatment with your insurance company, credit card company, or any other relevant authority or financial payer.**

I have read and my signature signifies my understanding and agreement to abide by the above.

Signature of patient or responsible party Date