



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? ☐ Internet _____, ☐ Physician _____ ☐ Friend/relative _____
Do you have an Advance Directive/Health Care Power of Attorney? _____
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: _____



PATIENT HEALTH QUESTIONNAIRE

Do you have or have you ever had the following?

	Yes	No		Yes	No
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Seizure/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmias	<input type="checkbox"/>	<input type="checkbox"/>			
Abnormal EKG	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism/Addiction problems	<input type="checkbox"/>	<input type="checkbox"/>
Other Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Depression/Bipolar	<input type="checkbox"/>	<input type="checkbox"/>
Poor leg circulation	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, what type? _____	<input type="checkbox"/>	<input type="checkbox"/>
Easy bleeding/bruising	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>			
Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune Disease _____	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorder, eczema, psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clot/DVT	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores, Herpes Simplex Virus	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Facial weakness, Bell's Palsy	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>			
Reflux/GERD	<input type="checkbox"/>	<input type="checkbox"/>	Cancer of any kind, type? _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>

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?



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 (vaping included)? 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 ☐ 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 the patient information and insurance form before being seen by the doctor.

All co-pays and patient responsible charges are due at the time of service. If your insurance applies any of your charges 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 for 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 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 the patient information and health form before seeing the doctor.

The consultation fee is \$100 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 you have questions about this, ask a staff member. The balance of the surgical fee is due 2 weeks prior to surgery.

We request that you make your final payment for Dr. Boll in the form of a Cashier's check, otherwise you will be subject to a 3% fee of the amount owed if paid by credit card. We also accept cash and financing.

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 the prevailing fees of the operating room, anesthesia, and the surgeon fees.

Additional out of pocket costs 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 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