Rodney A. Green, M.D. FACS
Plastic & Reconstruction Surgery/Hand Surgery

Name :_____ Date: _____
Birthdate _____ Sex: _____ Age: _____
Address :_____ City: _____ State _____
Zip Code: _____ Phone: _____ Cell: _____
E-Mail:_____
If you do **not** want to receive our e-mail - Check here ____

Social Security Number (required) _____ _____ _____

Marital Status: Single __ Married __ Divorced __ Widow __

Specific problem for which you are seeking consultation:_____
_____
Have you consulted any other Doctors: __ YES __ NO
If so please list their names:
_____
Patient referral source:_____ Family Doctor: _____
Address: _____ City _____ State _____ Zip _____

Employer:_____ Occupation _____
Address _____ Phone ( ) _____ City _____
State _____ Zip _____ Full Time: _____ Part Time _____
Has this office ever treated any member of your family? Yes ___ No ___
If so Whom: _____ Relationship _____

Emergency Contact: _____ Relationship _____
Phone ( ) _____

Insurance Information: - PLEASE GIVE SECTRETARY YOUR INSURANCE CARD
Subscriber Date of Birth _____ Relationship _____
Company _____ ID # _____ Group # _____
Tel # _____ Co-Pay $ _____ Referral needed? ____ yes, _____ No

Is this a work related injury? ____ Yes, _____ No. Date of Injury _____
Workers Com[# _____ Name of MCO _____
(If you have your MCO card, please give it to the secretary)
May we leave information on your answering machine with a family member regarding your appointments? ____ Yes, ____No.

Race: _____ Ethnicity: ___ Hispanic ___ Non Hispanic ___ Declined Language: English _____ Other _____

Are you allergic to any medications? Yes ____ No ____
If Yes, which ones(s) _____

Have you ever reacted badly to being put to sleep for surgery?	Yes ____	No ____
Has any member of your family reacted badly?	Yes ____	No ____
Have you ever had a bad reaction to local anesthetic (Novocain, etc)?	Yes ____	No ____
Are you allergic to adhesive tape?	Yes ____	No ____
Do you have high blood pressure?	Yes ____	No ____
Have you ever had scarlet fever or rheumatic fever?	Yes ____	No ____
Do you bleed easily from (cuts, surgery, tooth extractions)?	Yes ____	No ____
Are you a poor healer?	Yes ____	No ____
Do you form large scars or keloids?	Yes ____	No ____
Do you have any skin diseases, hives, eczema or rash?	Yes ____	No ____
Do you have frequent infections or boils?	Yes ____	No ____
Have you taken steroid medications, cortisone?	Yes ____	No ____
Or ACTH, if so, how long ago	Yes ____	No ____
Do you have shortness of breath with walking?	Yes ____	No ____
Do you have, or have you had any back trouble?	Yes ____	No ____
Does your religion prohibit blood transfusions?	Yes ____	No ____
Do you have, or have you had any significant emotional problems?	Yes ____	No ____
Have you ever had or been advised to seek psychiatric care?	Yes ____	No ____

Have you had any illnesses or disorder of the following (Check if answer is YES)

□Brain (including strokes, epilepsy)	□Intestines	□Breast
□Heart or blood vessels	□Diabetes	□Reproductive
□Nervous system	□Lungs	□Ears
□Stomach	□Face (paralysis)	□Liver
□Eyes (including glaucoma, dryness)	□Blood	□Arms or legs
	□Nose, Sinuses, Throat	□Bones or joints
	□Urinary system	

If "Yes" to any of the above, please explain:

_____

_____

_____

HEIGHT _____ WEIGHT _____ Any major weight gain or loss within the last year, if so explain: _____

Medical History

General Health: □Good □Fair □Poor If not "Good" please explain:

_____

_____

_____

Have you had children? If so How Many? _____

How long ago was your most recent physical check up? _____

Did it include an Electrocardiogram? □Yes □No – Chest x-ray? □Yes □No

Name and Address of the Doctor: _____

_____

Serious Illness (Please List) _____

_____

Previous Surgery (Please List)

Operations	Year	Hospital	City	Surgeons Name	Local or Gen. Anesthesia

_____

_____

_____

_____

Have you had significant complications after any of these operations ____ Yes, ____ No.

_____

_____

INJURIES

Type	Year	Hospital	Doctor	After Effects

_____

_____

_____

_____

MEDICATIONS, DRUGS:

What is your approximate daily consumption of the following:

Coffee or Tea _____ a day, Alcohol _____ a day, Tobacco _____ a day.

Other intoxicating or mind altering drugs (specify) _____Does anyone else in your household smoke? _____ How much? _____.

Please list ALL your medications and their dosages (including prescription and over the counter).

_____

_____

_____

PHARMACY OF CHOICE: _____ **PHONE NUMBER:** _____

We would like to welcome you into our practice. We strive to provide quality care for our patients in a pleasant, comfortable atmosphere. Please understand that payment of your bill is considered part of your treatment.

If you are covered by health insurance, we will gladly submit the necessary forms to your insurance company. From our experience we have found that few insurance plans cover the complete cost involved. Your policy is a contract between you and your insurance company. It is important that you understand its provisions. If you need a referral to see Dr. Green or Karen Bird our O.T. it is your responsibility to obtain it.

1. To make the necessary arrangements to get your referral from your primary physician.
2. It is also your responsibility to keep track of the number of referrals from your initial visit to your end date, and if necessary to obtain more referrals. Otherwise you will be responsible for your balance if these arrangements are not met.
3. We cannot guarantee payment for your claims or accept responsibility of negotiating your claim.

You will be required to pay your co-payment after each visit. Any deductible/coinsurance payment you will be billed. Secondary insurance billing will be submitted by our office to the insurance companies for which we participate. Otherwise, we can provide you with a copy of your bill for you to submit to your secondary insurance company for reimbursement.

We accept cash, check and all major credit cards for balances over $25.00. You as the contract holder for your insurance will receive and explanation of benefits from them; this will inform you of any outstanding balance you owe Dr. Rodney A. Green. Payment is due in full at the time you receive this statement, otherwise there will be a $5.00 service charge each month. The fee for returned checks is $25.00.

If your account is overdue or unpaid after Sixty (60) days, it will be turned over to collections.

We ask that you help us keep the cost of your health care down by paying promptly. I you have any questions regarding our policy please do not hesitate to discuss them with us. Your cooperation is deeply appreciated. Thank you.

I have read and understand this policy.

_____ _____

Signature of Responsible Party Date

Photographic Release and Consent
For
Rodney A. Green, M.D. FACS

I understand and accept that I may be recognized from my likeness or case history. Nevertheless, I authorized my plastic surgeon to use my photographs, videotapes and case information in the following educational and scientific settings. Care will be taken to avoid revealing my identity.

Photographs may be used for the following:

- My surgeon's office patient educational materials.
- My surgeon's office of pre-and postoperative patient photographs available to prospective patients for viewing in the office.
- My surgeon's web site or web sites that are linked.
- For medical lectures and articles.

Date: _____ Date: _____

Patient Signature _____ Witness Signature _____

Print Name _____ Print Name _____