



WELCOME TO OUR OFFICE!

1879 Nightingale Lane, Suite A-2
Tavares, Florida 32778
Ph: 352-742-0079
Fx: 352-742-0059

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

May we send e-mail to you? YES NO E-mail address \_\_\_\_\_

Spouse Name \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Primary Ins \_\_\_\_\_ Secondary Ins \_\_\_\_\_

Subscriber/Responsible Party (if other than pt)

Name \_\_\_\_\_ Relation \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security \_\_\_\_\_

Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Emergency Contact

Name \_\_\_\_\_ Relation \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Any restrictions on calling your home, work or cell? YES NO
If yes, explain \_\_\_\_\_

Any restrictions on correspondence? YES NO
If yes, explain \_\_\_\_\_

How did you learn about our practice? \_\_\_\_\_

If referred by an individual, may we send a thank you letter? YES NO

PLEASE GIVE YOUR INSURANCE CARD(S) & A PHOTO ID TO OUR FRONT DESK TO COPY

If you are a member of an HMO or PPO you may need authorization from your primary care physician to see our doctors. We may not be able to see you if authorization cannot be secured. We will be happy to reschedule your appointment once authorization has been obtained or you may choose to accept financial responsibility for your visit.

I authorize the release of any medical or other information necessary to process insurance claims. I authorize my insurance benefits to be paid directly to Plastic Surgery Center of Lake County. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

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Signature (patient/responsible party)

Date

# HEALTH HISTORY

Correct answers to the following questions allow our doctors to treat you on a more individual basis, providing the care appropriate to your particular needs.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Today's Date:

■ Why are you seeking a plastic surgery consult? \_\_\_\_\_

Please answer each question by checking yes or no. If in doubt, leave blank:

- Are you in good health now? ..... Yes / No
- Are you under the care of a physician? ..... Yes / No  
If so, what is the condition being treated? \_\_\_\_\_
- Have you ever been hospitalized or had a serious illness? ..... Yes / No  
If yes, please explain \_\_\_\_\_
- (Women) : Are you pregnant? If so, give due date: ..... Yes / No
- Do you use tobacco in any form? ..... Yes / No  
If yes, how much / often? \_\_\_\_\_  
If you quit, how long ago? \_\_\_\_\_
- Do you now or have you ever regularly consumed alcoholic beverages (more than 2 drinks / day for men, 1 / day for women)? ..... Yes / No

Do you have, or have you ever had, any of the following?

	YES	NO	YES IN PAST BUT NOT NOW
<b>GENERAL</b>			
Tire Easily			
Marked Weight Change			
Night Sweats			
Persistent Fever			
<b>SKIN</b>			
Eruptions, Rash, Hives			
Change in Skin Color			
<b>EYES</b>			
Visual Change			
Glaucoma			
<b>EARS</b>			
Loss of Hearing			
ringing in Ears			
<b>NOSE</b>			
Frequent Nosebleeds			
Sinus Problems			
<b>THROAT</b>			
Soreness / Hoarseness			
<b>NERVOUS SYSTEM</b>			
Stroke			
<b>HEADACHES</b>			
Convulsion / Epilepsy			
Numbness / Tingling			
Dizziness / Fainting			
Psychiatric Treatment			
<b>ENDOCRINE</b>			
Thyroid Condition / Goiter			
Diabetes			
If so, do you take medicine			
Family history of diabetes			

	YES	NO	YES IN PAST BUT NOT NOW
<b>HEART / BLOOD VESSELS</b>			
Rheumatic Fever			
Heart Murmur			
Chest Pain / Discomfort			
Heart Attack / Trouble			
Shortness of Breath			
Swelling of Ankles			
High Blood Pressure			
Congenital Heart Disease			
Artificial Heart Valve			
Pacemaker			
Heart Surgery			
Other (List on Reverse)			
<b>BONE / MUSCLES</b>			
Arthritis / Rheumatism			
Artificial Joints			
<b>DIGESTIVE SYSTEM</b>			
Hepatitis			
Jaundice			
Ulcers			
Change in Appetite			
Black / Bloody or Pale Stools			
<b>URINARY</b>			
Kidney Disease			
Increase in Frequency (night)			
Burning on Urination			
Urethral Discharge			
Bloody Urine			
Venereal Disease			
<b>BLOOD</b>			
Bruise Easily			
Anemia			
Blood Transfusion			

# HEALTH HISTORY

- Are you allergic to any medications? If so, please list them, as well as the reaction.

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- List all *prescription* medications you are currently taking:

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- List all *over the counter* medications you are currently taking:  
(Including vitamins, herbals, aspirin, ibuprofen, acetaminophen, etc)

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- Is there any disease, condition, or problem not listed, that you think we should know about?  
Or, is there any activity your doctor says you cannot do? If so, please explain.

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- Name of your primary care physician \_\_\_\_\_ Phone \_\_\_\_\_
- Name of the referring physician \_\_\_\_\_ Phone \_\_\_\_\_

- Please list any previous surgeries, and the date performed:

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- Is there anything else you would like the doctor to know? \_\_\_\_\_

To the best of my knowledge, all the preceding answers are true and correct.  
If I ever have any change in my health, or change my medication, I will inform the doctor at the next appointment.

Signature of patient, Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of Doctor \_\_\_\_\_ Date \_\_\_\_\_

## BOSSHARDT & MARZEK - FINANCIAL POLICY

I understand and agree to the following terms of Bosshardt & Marzek's financial policy:

- Payment is due in full at the time of service for self-pay patients and for cosmetic procedures.
- We bill insurance as a courtesy, and balances are ultimately the patient's responsibility. If we cannot collect insurance payment within 90 days, the balance will be assigned to the patient.
- Co-payments and co-insurance (where a percentage of charges is assigned to the patient) are due at the time of visit.
- Patients must provide proof of insurance at the time of visit. If the patient's insurance card is not presented when there is a change in coverage the patient will be responsible for full payment at the time of service.
- Patients are responsible for knowing their insurance coverage and benefits. Although we make every attempt to accurately confirm our participation in various plans, it is ultimately the patient's responsibility to verify coverage. We recommend calling your insurance carrier prior to your visit to verify coverage. Rejection of all or part of your medical insurance claim by your insurance company does not relieve your financial obligation to Bosshardt & Marzek.
- Payment for patient bills is due upon receipt. After we receive insurance payment, there may be a remaining patient balance for deductibles, additional co-payments, non-covered services or any other charge the insurance carrier may assign to the patient. Payment is due immediately upon receiving a bill from Bosshardt & Marzek.
- Prior balances are due at the time of visit. Returning patients must pay their bill if they arrive for an appointment and have an outstanding balance on their account.
- Accounts not paid within 120 days will be sent to a collection agency, and may be subject to an additional 35% added fee of total balance.
- Bosshardt & Marzek accepts cash, checks\* and all major credit cards. If a check payment is returned by the bank, a \$35 fee will be applied to the patient's account. Patients who have a returned check must use cash or credit card only for all future payments. \*Checks for major surgeries must be in the form of a bank or cashier's check. All checks are made payable to: **Plastic Surgery Center of Lake County, P. A.**

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**Patient Signature**

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**Print Name**

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**Date**