Patient Information

Full Name: ____

Address: ____

City/State/Zip: _____________________________________

Home Phone: ______________________________

Cell Phone::______________________________

Work Phone: _______________________________

Email: ____

Date of Birth: ______/_______/_________

Social Security No: _____-______-_________

Race/Ethnicity: _________________________________

Employment Status: Full / Part / Retired / Other

Employer: ___________________________________

Marital Status (Married / Single / Widowed / Other)

Circle one:

Self Referral   Friend Referral   Doctor Referral

Referring Doctor: _______________________________

Legal Guardian of Patient Information needed.

Relationship to Patient: _________________________

Full Name: _____________________________________

Address: ____

Date of Birth: ____/_____/______

SS#:_____-____-_____   Phone #:________________

Emergency Contact (That Does Not Live With You)

Name________________________________

(Relationship)_______________________

Phone: _________________________________

Do we have permission to leave a message?

Home: Y or N   Work: Y or N   Cell: Y or N

May we discuss your medical condition with someone in your house hold? Y or N

If so, who: ____________________ (Relationship) ____________

Insurance/Subscriber Information

(Required if Patient is a Dependent on the Policy)

Insurance Co.:_____________________________

Subscriber Name: _____________________________

DOB: ______/______/______   SS#:_______-_____-______

Employer: ______________________________________

Consent for Photography

I, ________________________________ consent for the purpose of my medical care the use of photography. I understand that such photographs will be seen by other medical personnel that are involved in my care. I also understand that such photographs will not be shown to non-medical personnel without my express consent. This does not include health insurance employees that may be shown my photographs in order to justify approval of a proposed procedure or billing.

****SIGNATURE PATIENT OR RESPONSIBLEPARTY:**

x_________________________________ DATE:____/____/____

***** Patient will be responsible for paying co pays or office surgery deposits before seeing the doctor.**

*****Any returned check due to "insufficient funds" will incur an additional $40 penalty to the acct.**

Acknowledgment of Privacy Practices

I HAVE RECEIVED AND HAD AN OPPORTUNITY TO ASK QUESTIONS CONCERNING THE GULF COAST PLASTIC & RECONSTRUCTIVE SURGERY NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.

_________________________________   _________________

Patient or Patient Responsible Signature   Date

FORREST S. WELLS, MD & Mary Elizabeth Cordle, NO

Gulf Coast Plastic Surgery & Dermatology, PLLC

4509 Gibson Road, Ocean Springs, MS 39564 Phone: 228.872.3993 Fax: 228.872.3992

AUTHORIZATION/RESPONSIBILITY AGREEMENT

1. I, the undersigned as the patient or his/her authorized legal representative, do hereby authorize **Forrest S. Wells, MD or Mary Elizabeth Cordle, NP** to release to my insurance company or other appropriate agencies information necessary to validate this claim for billing purposes.

2. **Forrest S. Wells, MD or Mary Elizabeth Cordle, NP** is also hereby authorized to release to any other physicians or medical entity information as needed for treatment, care of the insured.

3. I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to **Forrest S. Wells, MD. or Mary Elizabeth Cordle, NP** A copy of this form can be considered as an original for insurance purposes. I acknowledge and understand that I am responsible for all of the charges for the services rendered to me, or the indicated person for whom I am financially responsible. Although I have requested the doctors to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in full in a reasonable amount of time. If for any reason any portion of the bill is not paid by the insurance company, I further agree to make arrangements for prompt payment of the bill.

Pt. Initials: ______

STATEMENT TO PERMIT PAYMENT OF MEDICARE/MEDICAID BENEFITS TO FORREST S. WELLS, MD or Mary Elizabeth Cordle, NP

I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to Forrest S. Wells, MD or Mary Elizabeth Cordle, NP for services furnished to me by physicians associated with Forrest S. Wells, MD or Mary Elizabeth Cordle NP. I authorize Forrest S. Wells, MD or Mary Elizabeth Cordle, NP to release to Centers for Medicare/Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Pt. Initials: ________ ***(Initial only if you have Medicare or Medicaid benefits.)***

Gulf Coast Plastic Surgery & Dermatology accepts payment for professional services in the form of cash, check, credit card or patient financing. All patients will be required to establish a financial arrangement when services are rendered. In addition, we accept insurance from all major insurance companies. ***PLEASE BE AWARE THAT FEW INSURANCE COMPANIES ATTEMPT TO COVER ALL MEDICAL COSTS. EACH PATIENT IS REQUIRED TO MAKE A DEPOSIT PRIOR TO SURGERY.*** Your insurance coverage is a contract between you and your insurance carrier. We will assist you in maximizing your insurance benefits and in obtaining necessary pre-certifications. As a courtesy we will review your insurance coverage, estimate your insurance payment, review your insurance form and file your claim with the carrier. To avoid any misunderstanding, we will require you to assign all insurance benefits for professional services directly to our office. If you request your insurance company to pay you directly, we will require full payment from you at the time of service. You will be notified when the insurance carrier remits payment to our practice. We will apply this payment to your account and refund any credit balance within 30 days.

If an insurance problem occurs you will be asked to assist us in contacting your insurance carrier. We feel it is necessary to work together to resolve any insurance problem. ***YOU WILL BE RESPONSIBLE FOR ANY PORTION OF YOUR BILL WHICH IS DENIED OR NOT PAID BY YOUR INSURANCE CARRIER.***

If your medical care does require surgery at another facility or labs please be aware that you and or your insurance carrier could be charged by that entity. Charges and statements from Gulf Coast Plastic Surgery & Dermatology will not reflect outstanding balances from other facilities.

In addition, if an outstanding balance is not paid in full after receiving statements and delinquent notices from Gulf Coast Plastic Surgery & Dermatology, and no arrangements are made for payment, I acknowledge and understand that my account balance may be turned over to a collections agency. In the event that an account is turned over to a collections agency, I further acknowledge and understand that I may be responsible for up to fifty percent (50%) of the balance for fees and expenses.

I have read, understand and agree to these policies.

______________________________ ______________

Signature of Patient or Responsible Party **Date**

Medical History

Patient Name: ___________________________

Height: ______ foot ______inches Weight: __________LBS

MEDICATIONS:____

____

____

Past Medical History: (Please circle all that apply)

Anxiety	Depression	Hypothyroidism
Arthritis	Diabetes	Leukemia
Asthma	End Stage Renal Dz	Lung Cancer
Atrial Fibrillation	Gastric Reflux	Lymphoma
Bone Marrow Transplant	Hearing Loss	Prostate Cancer
BPH	Hepatitis	Rheumatoid Arthritis
Breast Cancer	High Blood Pressure	Radiation Treatment
Colon Cancer	HIV/AIDS	Seizures
COPD	High Cholesterol	Stroke
Coronary Artery Disease	Hyperthyroidism	None

Other: ____

Past Surgical History: (Please circle all that apply)

Appendix Removed	Heart Transplant	Pancreas Removed
Bladder Removed	Joint Replacement: Hip	Prostate Removed: Cancer
Breast Reduction: R L B	Joint Replacement: Knee	Prostate Biopsy
Breast Implants: R L B	Joint Replacement	Spleen Removed
Mastectomy: R L B	Kidney Biopsy	Testicles Removed
Lumpectomy: R L B	Kidney Removed: R L	Tonsillectomy
Colon Removed	Kidney Stone Removed	Hysterectomy: Total
Gallbladder Removed	Liver Transplant	Hysterectomy: Partial
Coronary Artery Bypass	Ovaries Removed	Skin Cancer Removed
Mechanical Heart Valve	Cosmetic:	Other:

Skin Disease History: (Please circle all that apply)

Acne	Actinic Keratosis	Asthma
Basal Cell Carcinoma	Blistering Sunburns	Dysplastic Nevus
Dry Skin	Eczema	Flaky or Itchy Scalp
Hay Fever/Allergies	Melanoma	Poison Ivy
Psoriasis	Shingles/Chickenpox	Squamous Cell Carcinoma
Cold Sores/Fever Blisters		

Allergies: (Please enter all Drug Allergies)

____

____

Family Medical History: (Immediate Family, Please include any skin cancer)

____

____

Special Alerts (Please circle all that apply)

Pacemaker/AICD	Allergy to Lidocaine	Artificial Joints
Artificial Heart Valve	Premedication Prior to Procedure	Pregnant or planning
Blood thinners	History of Fainting	HIV/AIDS
Hepatitis C	History of MRSA	Organ Transplant
Breastfeeding	Immunosuppression	Sensitivity to Epinephrine

HAVE YOU HAD A FLU SHOT WITHIN THE LAST YEAR: YES or NO

HAVE YOU HAD A MAMMOGRAM IN THE PAST 2 YEARS: YES or NO

HAVE YOU HAD A COLONOSCOPY IN THE LAST 9 YEARS: YES or NO

If you are over the age of 60, have you had the Pneumonia Vaccine: YES or NO

If so, when: ____/_____/_____

Tobacco Use:	**Alcohol Use:**	**Recreational Drug Use:**
A) Smoker	A) None	YES or NO
B) Smokeless Tobacco	B) Rarely	
C) Neither/Non- Smoker	C) Socially	
	D) Daily	

***PATIENT OR GUARDIAN SIGNATURE: X*____**

***Date:* _________________**