Patient Information

Full Name:_____

Address:_____

City/State/Zip: _____

Home Phone: _____

Cell Phone::_____

Work Phone: _____

Email: _____

Date of Birth: _____/_____/_____

Soc Sec#:_____-_____-_____

Race/Ethnicity: _____

Employment Status: Full / Part / Retired / Other

Employer:_____

Marital Status (Married / Single / Widowed / Other)

Spouse's Name: _____

Emergency Contact *(that does not live with you)*

Name:_____

(Relation)_____

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 dependant on the policy)

Insurance Co.:_____

Subscriber Name:_____

DOB:_____/_____/_____ SS#:_____-_____-_____

Employer:_____

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 #:_____

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
Gulf Coast Plastic & Reconstructive Surgery, 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** to release to my insurance company or other appropriate agencies information necessary to validate this claim for billing purposes.

2. **Forrest S. Wells, MD** 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.** 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
I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to Forrest S. Wells, MD for services furnished to me by physicians associated with Forrest S. Wells, MD. I authorize Forrest S. Wells, MD 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 & Reconstructive Surgery 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 and Reconstructive Surgery 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, 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**

Patient Medical History

Patient Name: _____ Height: _____ft_____in Weight:_____LBS

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: ____/_____/_____

Are you taking any blood thinners? (Plavix, Aspirin, Coumadin) **YES or NO**

If YES, name of Cardiologist: _____

Are you currently in Pain Management? Yes or No If YES, name of Physician: _____

List any Drug Allergies: _____

Past/Current Medical Conditions: Please check ones that apply.

Asthma		High Blood Pressure	
Breast Cancer		Lung Disease	
Cancer		Melanoma	
Chest Pain/Tightness		Reflux	
COPD		Renal Insuffiency	
Diabetes		Skin Cancer	
Heart Disease		Stroke	
Hepatitis (please indicate A, B, or C)		Thyroid Disorder	
HIV or Aids			

List all Current Medications:

Other: _____

List Previous Operations: _____ Are you on HOSPICE? Y OR N

Family History: Please check ones that apply. (Immediate Family Only)

Family History		Relation to patient
Cancer		
Diabetes		
Heart Disease		
High Blood Pressure		

Tobacco Use:

A) Smoker B) Smokeless Tobacco C) Neither/Non- Smoker

PATIENT OR GUARDIAN SIGNATURE:

X_____

Date: _____

*****If reason for appointment is related to an accident, injury or workers comp the following information is required:**

Type of Injury: _____

Date of Injury: _____/_____/_____ Where (home, work, school, etc) _____

Details of how injury occurred: _____