



KLEINERT KUTZ
HAND & AESTHETIC PLASTIC SURGERY

Kleinert Kutz Plastics & Aesthetic Patient Registration Form



KLEINERT KUTZ
HAND & AESTHETIC PLASTIC SURGERY

Patient Name: _____ DOB: _____ SS#: _____

Address: _____ Apt #: _____ City: _____

State: _____ Zip: _____ Home: (_____) _____ Cell: (_____) _____

Email address: _____

Sex: Male Female Marital Status: Married Divorced Single Widow Student (Y/N): _____ if yes – Full time Part time

Employer: _____ Employer Address: _____

Employer, City, State & Zip: _____ Work: (_____) _____

Referring MD, Address & Phone: _____

Emergency Contact: _____ Phone: (_____) _____ Relation: _____

Spouse's Name – if Insurance Policy Holder

Fill out only if your spouse is the policy holder on your insurance plan.

Spouse's Name: _____ DOB: _____ SS#: _____

Cell: (_____) _____ Work: (_____) _____ Employer: _____

Employer's Address, City, State & Zip: _____

Guarantor Information – if patient is a Minor

If insurance is through someone other than mother or father, please put their info at the bottom of this section.

Mother's Name: _____ DOB: _____ SS#: _____

Address (if different than above): _____ Cell: (_____) _____

Employer & Address: _____ Work: (_____) _____

Father's Name: _____ DOB: _____ SS#: _____

Address (if different than above): _____ Cell: (_____) _____

Employer & Address: _____ Work: (_____) _____

Other Responsible Party (If not Parents above): _____ DOB: _____

Relation: _____ SS#: _____ Phone: (_____) _____

Employer & Full Address: _____

Payment Information

We must obtain copies of ALL insurance cards if filing with your insurance policy.

Primary (check one): Personal pay or Personal Insurance – If using personal insurance, please fill out below.

Name of Insurance Co.: _____ ID #: _____

Name of Policy Holder: _____ Relation to Patient: _____

Secondary Insurance: _____ ID#: _____

Name of Policy Holder: _____ Relation to Patient: _____

Office Use Only

Hospital/Physician: _____ Date: _____ Xray #: _____



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**Consent to Treatment, Authorization to
Release Information and Payment Information**



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I hereby consent to the rendering of care, including diagnostic procedure and treatment, as the attending physician or physicians under their supervision consider appropriate and necessary. I understand that I will be informed of the risks of any proposed procedure and treatment and I should decline treatment unless such risks are explained to my satisfaction. I also consent to the taking of photographs in the course of medical treatment.

I hereby authorize the release of information regarding my condition and treatment to any referring or consulting healthcare personnel, and health, accident, auto or worker's compensation carrier, any agent, attorney or other representative purporting to act of my behalf, at any facility at which I may be treated, examined or evaluated.

I hereby authorize my current insurance carrier to pay Kleinert Kutz out any benefits due on this claim. I understand that I am financially responsible to the doctor for any charges not covered. I understand that Kleinert Kutz **may** or **may not** be a participating provider with my insurance carrier and it's **my responsibility** to verify this status with my insurance. I agree that any additional request for information form my insurance regarding coverage, coordination of benefits, or related questions will be answered by me in a timely manner, or the balance due will become my responsibility.

If I have insurance Kleinert Kutz will help me receive maximum benefits. All payments are due at time of service, such as co-payments, deductibles and/or any other fees deemed my responsibility. In the event this matter is referred for collections, I agree to pay all court costs, collection fee, and attorney fees associated with the collection of this account.

THIS IS A LEGALLY BINDING DOCUMENT – READ BEFORE SIGNING

I understand and agree that all of the provisions of this CONSENT TO TREATMENT, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT INFORMATION shall remain in full force and effect until revoked by me IN WRITING.

Patient Name (**please print**): _____

Signature(**patient or Legal Guardian**): **X** _____

If patient is a minor, they are _____ years of age. Date: _____

ACUTANE RELEASE

I acknowledge that I have not taken oral Pharmaceutical medication Accutane (or its equivalent) within the past twelve months. I understand the potential risks involved with Accutane therapy and the problems that could occur when employed in conjunction with skin care programs, treatments and surgery.

Patient (**please print**): _____

Signature: (**patient or Legal Guardian**): _____

Date: _____

Kleinert, Kutz and Associates

Plastic, Cosmetic and Aesthetic Service

Medical History

Name _____ Age _____ Date _____

Occupation _____ Weight _____ Height _____

Reason for this visit _____ Referred by _____

Have you seen other physicians regarding this issue? Yes _____ No _____ If so, how many? _____

Have you received unsatisfactory medical care? _____

Primary Care Physician _____ Phone # (_____) _____

Address _____ City, State, Zip _____

Have you ever had surgery or been hospitalized? Yes _____ No _____ If yes, please fill in the below:

OPERATION	ANESTHESIA (local or general)	DATE	ANY PROBLEMS?

Have you or anyone in your family had a problem, complication or reaction to anesthesia? If so, describe. _____

Smoking: Never Current smoker History of smoking -- If ever, number of years? _____ number of packs a day? _____

I drink **alcohol:** Never Rarely Monthly Weekly Daily

Do you use **illicit drugs?** Yes _____ No _____ If so, what kind(s)? _____ How Often? _____

Do you suffer or been diagnosed from any of the following ? (Circle all that apply)				
Cold sores/Herpes	Easy bruising/Anemia Prolonged bleeding/clotting problems, pulmonary embolis, swelling and blood clots of legs	Chest pain, Heart Disease, Heart surgery, stint placement, pacemaker, arrhythmia, angioplasty	Arthritis, osteo or rheumatoid	
Headaches	Thyroid	Cancer	Diabetes, type 1 or 2	
Dizziness/Fainting	Dependency/Alcoholism	High blood pressure	Birth control or estrogen medicine	
Lumps/masses of what area of the body	Epilepsy/Seizures, seizure medicine	Kidney disease or bladder problems	HIV+/Aids	
Vision issues/glaucoma, dryness of eyes	Changes in skin/moles, history of skin cancer, family history of skin cancer	Stroke	Varicose Veins	
Eating Disorder	Facial paralysis	Mental Illness/Psychiatric Care, depression	Bone disease	
Sleep apnea, cpap or bipap machine	Gout	Chronic pain, treatment under MD supervision	Hernia	
Chronic nausea, diarrhea, acid reflux, bowel, hiatal hernia, and or pancreas problems	Artificial joint replacement, list what area:	Bronchitis, pneumonia, lung disease, breathing problems, asthma., emphysema	Jaudice, ulcers, hepatitis, liver disease	
Currently being treated for chronic wound?	Currently on antibiotics for upper respiratory, urinary tract or tooth infection?	Disabled	History of VRE, MRSA	

Any other diagnosed problems not listed on previous sheet:

Does anyone in your family have a history of disease? _____

Are you currently taking cold medicines? _____

Are you currently taking lasix or dilantin? _____

Are you pregnant? _____ Are you trying to become pregnant? _____ Date of last menstrual period? _____

Do you regularly take aspirin, ibuprofen, Aleve, Motrin, Excedrin, Fish Oil, Vitamin E, multivitamins, blood thinners or Advil?
_____ If so, why? _____

History of taking these blood thinning **medicines**: Aspirin, Plavix, Warfarin, Coumadin, Xarelto, Effient, Pradaxa?

Have you ever had a blood transfusion? _____ Why? _____ Any reaction? _____

DRUG Allergies: Yes____, No____,

Please list all other allergies and reactions below:

LATEX ALLERGY: Yes____ No____

Current Medications & Dosages (Include hormones, birth control pill, antibiotics, vitamins and herbs):

Drug:	Dosage:	How often:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This information is true and complete to the best of my knowledge.

Signed: **X** _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of the Notice Of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

If you would like to have a copy of the Notice of Privacy Practices for your own records, please request one at the registration desk.

SIGNED: X _____ DATE: _____

If not signed by the patient, please indicate relationship to patient (e.g., parent, legal custodian)

Relationship: _____

Witnessed by: _____

IF THE PATIENT OR REPRESENTATIVE REFUSES OR IS UNABLE TO SIGN, INDICATE YOUR ATTEMPT TO OBTAIN A SIGNATURE BELOW.

[] Patient refused to sign this acknowledgement

[] Patient is unable to sign due to injury

DATE: _____ TIME: _____

EMPLOYEE: _____

WITNESS: _____

This acknowledgement applies to the following business entities:

Kleinert, Kutz and Associates PLLC
Christine M. Kleinert Institute for Hand and Microsurgery, Inc.
Kleinert Kutz Surgery Center
in affiliation with Floyd Memorial Hospital and Health Services