Patient Demographic Information

Patient's Name: ____ Birthdate: _____________________

Address: ___________________________________ Phone: C (   ) _____________ / H(   )___________

City: ____ Zip Code: ________________

E-Mail: ____ Last 4 digits of SSN:_______________

Primary Doctor:____

Who may we thank for referring you:____

Pharmacy Name & Address: ____ Phone: (   )____________

INSURANCE INFORMATION

Primary Insurance Co: ____

Address: ____________________________________ Phone: (   )________________/(   )______________

City/State: ____ Zip Code: ________________

Policy#:________________________ Group #:___________________________

Secondary Insurance Co: ____

Address ____________________________________ Phone: (   )________________/(   )_______________

City/State ____ Zip Code: ________________

Policy#:________________________ Group #:___________________________

I the undersigned, assign, transfer and set over to Suresh Koneru, M.D. all of my rights, title and interest to my medical reimbursement benefits under my insurance policy above. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize Dr. Suresh Koneru to release any information necessary to secure the payment of benefits and to aid in my treatment. If there is a balance due I will receive three (3) statements and if I do not respond or send payment my account will be sent to collections. If surgery is required all prior balances due will need to be paid two (2) weeks before surgery date. I understand that in connection with the medical services, photographs of the involved area(s) will be taken. Such photographs and information relating to my case may be confidentially published in professional journals or medical books, or used for any other purpose that Dr. Suresh Koneru may deem proper in the interest of medical education, knowledge, or research.

PATIENT OR GUARDIAN:____**Date:**__________________

PATIENT HEALTH QUESTIONNAIRE

What is the reason for your visit? ____

Medication Allergies/Reaction: ____

Medications:____

Vitamins or Herbs: ____

Height: __________________ Weight:_________________

Race: __________________ Ethnicity:____________________ Preferred Language: ___________

SYSTEM	YES	NO	DATE
Eyes			
Glaucoma			
Glasses			
Cataracts			
Other			
Ears, Nose, Mouth, Throat			
Ear Problem			
Sinus Problem			
Decreased Hearing			
Dental Work			
Nose Bleds			
Other ENT Problems			
Gastrointestinal			
Ulcers			
Colitis			
Diverticultits			
Hepatitis			
Gall Bladder			
Other GI Problems			
Skin			
Lesions			
Scars			
Varicose Veins			
Rashes			
Skin Cancers			
Other Skin Problems			
Psychiatric			
Anxiety			
Depression			
Other Psychiatry Problems			

SYSTEM	YES	NO	DATE
Cardiovascular			
High Blood Pressure			
Heart Attack			
Heart Murmur			
Other Heart Problems			
Respiratory			
Asthma			
Bronchitis			
Tuberculosis			
COVID-19			
Other Lung Problems			
Musculoskeletal			
Arthritis			
Swelling			
Muscle Aches			
Other Muscle Problems			
Neurological			
Seizures			
Stroke			
Paralysis			
Other Nerve Problems			
Endocrine			
Diabetes			
Hyperthyroid (high)			
Hypothyroid (low)			
Other Endo Problems			
Family History			**WHO?**
Cancer			
Diabetes			
Heart Disease			

SYSTEM	YES	NO	DATE
Hematological			
Bleed Easily			
Bruise Easily			
Bleeding Disorder			
Anemia			
Family history bleeding			
Other Heme Problems			
WOMEN ONLY			
Tender Breasts			
Lumps or Masses			
Fibrocystic Disease			
Menstrual Problems			
Date of Last Mammogram			

LIFESTYLE	YES	NO	AMOUNT
Alcohol Use			
Cigarette Use			
Other Tobacco Use			
Vaping			
CBD			
Marijuana			
Other Drug Use			

Date of Last Menstrual Period

Past Surgery (please list dates and any problems with anesthesia or surgery):

Any other medical problems: ____

DISCLOSURE OF INFORMATION

Please list the name and phone number of any alternate contact that we can share info with:

____ (_____)_____________________

Name and Relationship Number

____ _________________________

SIGNATURE OF PATIENT/GUARDIAN DATE

ACKNOWLEDGEMENT OF 24 HOUR CANCELLATION AND "NO SHOW" POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Advanced Concepts in Plastic Surgery reserves the right to charge a fee of $25 for all missed appointments and "no show" appointments. If you must cancel, a 24-hour notice is required.

Missed appointment and "no show" appointment fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to scheduling your next appointment. Multiple "no shows" and cancellations will be grounds for termination from this practice.

By signing, you acknowledge that you have received this notice and understand this policy.

______________________________ ____________________

SIGNATURE OF PATIENT/GUARDIAN DATE

ACKNOWLEDGEMENT OF REVIEW OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

______________________________ ____________________

SIGNATURE OF PATIENT/GUARDIAN DATE

ACKNOWLEDGEMENT OF eMAIL PRACTICES

From time to time we will send emails with valuable clinical, promo offers, as well as practice information. You may always opt out of the emails, but signing here acknowledges that you agree to receive emails from us. We prefer not to email sensitive personal health information unless you request we do so.

______________________________ ____________________

SIGNATURE OF PATIENT/GUARDIAN DATE