Simmonds
Plastic Surgery Care
Cosmetic Surgery for a Natural-Looking Result
480.905.9211

PATIENT REGISTRATION
(Please print, read and complete ***ALL*** Items)

DATE: _____

How did you hear about us? _____ **E-Mail:** _____

Patient Name: _____ **Sex:** M / F

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Date of Birth: _____ **Age:** _____ **SS#:** _____

Cell #: _____ **Home #:** _____ **Work #:** _____

Marital Status: (circle one) Single Married Divorced Separated

If patient is under 18, parent or guardian's name: _____

Occupation: _____ **Employer:** _____

Spouses Name: _____ **Date of Birth:** _____ **SS#:** _____

Employer: _____ **Work Phone #:** _____

NEAREST RELATIVE (Not living with you) FOR EMERGENCIES

Name: _____ **Relationship:** _____

Address: _____ **Phone #:** _____

INSURANCE INFORMATION: (Submit photocopy of insurance card)

Primary Insurance Carrier: _____ **ID#:** _____

Group #: _____ **Policy Holder:** _____

Secondary Insurance Carrier: _____ **ID#:** _____

Group #: _____ **Policy Holder:** _____

I hereby authorize the release of any information acquired in the course of my examination and treatment to my insurance carrier(s) to satisfy any claims that are filed, and further authorize payment directly to Arizona Craniofacial Plastic Surgery Center, or the Physician rendering services.
I understand that Medical Services NOT covered by my insurance will be my responsibility and are due and payable at the time services are rendered.

_____

Signature/Responsible Party Date

Date: _____ **Patient Name:** _____ **DOB:** _____

Reason for visit today: _____

Name of Primary Care Physician: _____ **Address:** _____

Physician Telephone: _____

ALLERGIES: _____ **Reaction:** _____

Current Medications/Herbal Supplements: _____

Are you a smoker? No Yes (roughly _____ a day) **Do you consume Alcohol?** Daily Socially Never

Review of Medical History:

Height _____ **Weight** _____

Are you pregnant? _____

Could you be pregnant? _____

Previous Surgeries: _____

_____

_____

Recent Hospitalization: _____

_____

_____

Any Injuries: _____

_____

_____

Have you ever had:	Yes	No	When? (year, date)
Diabetes			
Cancer			
Anemia			
Heart Trouble			
High Blood Pressure			
Kidney/Bladder Problem			
Bleeding Disorder			
Gout			
Epilepsy/Seizures			
Asthma/Hay fever			
Neurological Disease			
Mental Illness			
Stroke			
Blindness/Glaucoma			
Thyroid Problem			
Stomach/Ulcer			
TB/Valley Fever			
Hepatitis			
HIV/Immune Disease			
Arthritis			
Emphysema			
Drug/Alcohol abuse			
Other: _____			
Other: _____			

For Dr Simmonds Review & Signature:

_____ Date: _____

The above information is to the best of my knowledge a true statement of my current physical condition.

Signature: _____ **Date:** _____

Consent to treat a minor: I hereby give my consent for treatment:

Signed: _____ Date: _____
(Parent or Legal Guardian)

ARIZONA CRANIOFACIAL & PLASTIC SURGERY, P.C. PRIVACY POLICY:

Arizona Craniofacial & Plastic Surgery, PC collects information about patient's medical conditions, histories, medications and family illnesses. We understand the sensitive nature of this information and collect what is necessary to perform his or her job. Arizona Craniofacial & Plastic Surgery, PC physicians and employees must not release the patient's information unless authorized to do so which is required by law.

Generally, Arizona Craniofacial & Plastic Surgery, PC will honor a patient's request to release his or her medical records to a third party (including a third party payer) only with a release from the patient. This release should contain at the minimum: the patient's full name, address and date of birth; the name and address of the provider who is to release the record; the individual or entity to whom the record is to be released; the specific information being requested; the date the release was signed; and the signature of the patient or the patient's legally authorized representative.

Arizona Craniofacial & Plastic Surgery, PC will release psychiatric records and medical records relating to drug or alcohol treatment received from federally supported programs only when the patient's authorization specifically refers to these areas.

A subpoena for the production of medical records, called a subpoena duces tecum, does not need to be accompanied by a patient authorization for Arizona Craniofacial & Plastic Surgery; PC will not honor a subpoena requesting psychiatric, psychological, federal substance abuse program and sexually transmitted disease records without a valid patient authorization.

In an emergency situation, Arizona Craniofacial & Plastic Surgery, PC will release a patient's medical record information when requested by an institution or the physician treating the patient; however, Arizona Craniofacial & Plastic Surgery, PC must verify the name of the institution and the person requesting the information as part of the callback process.

If you should need any more information about our privacy policy you may contact our office manager at 480-905-9211.

_____ _____

Patient Signature **Date**

Important Nicotine Notice

Please be advised that the use of tobacco is detrimental to wound healing and can cause tissue neurosis (loss of tissue). This loss of tissue can cause extensive scar tissue and disfigurement, which may require several additional surgeries to attempt correction. However, these deformities may never be able to be corrected.

Tobacco use, nicotine gum, and/or nicotine patches should be discontinued at least three weeks prior to having any surgery, and must be discontinued at least six weeks after surgery. Second hand smoke (exposure to nicotine smoke from another person) can cause the same above problem and should be avoided for the same time period; three weeks prior to surgery and six weeks after surgery.

I do hereby certify that I have carefully read the above notice, and that the explanations referred to herein were explained to my satisfaction, and that I fully understand the risks, and complications of nicotine use before and after a surgical procedure. I understand and agree to abide, without exception, with the terms of this notice.

PATIENT SIGNATURE_____ **DATE**_____

WITNESSED BY_____ **DATE**_____
(Office Staff Only)

Cosmetic Patients Payment Policy
(Surgery scheduling)

In order to schedule surgery we must secure a deposit in the amount of $750 to precede, which is ***non-refundable***, and only good for up to one year. ***Surgical fees are due in full 10 days prior to surgery***. All lab work and pre-operative testing must be completed and reviewed prior to surgery. In the event the surgery has to be canceled due to patient failure to meet these requirements all deposits and surgical fees are non-refundable.

I also understand that in the event of additional charges assessed by the surgical facility centers, such as, but not limited to, scheduled surgery time running over or other incidental charges, will be the patients responsibility as these occurrences and fees are out of the control of Dr Simmonds.

We also understand that a situation may arise that could force you to postpone your surgery. Without adequate advance notice this not only affect's Dr. Simmonds schedule, Operating Room, Anesthesiologist schedule as well as staff. Therefore, ***any cancellation 7 days or less from scheduled procedure will result in forfeiture of 50% of the surgeon's fee. This amount is non-refundable.*** If surgery is rescheduled within 60 days of original date this amount can be applied.

PATIENT SIGNATURE_____ **DATE**_____

WITNESSED BY_____ **DATE**_____
(Office Staff Only)