BROWN
PLASTIC SURGERY

Patient Information Form

C

Today's Date: _____

PATIENT INFORMATION:

First Name: _____ **M.I.:** _____ **Last Name:** _____

Address: _____

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

Date of Birth: _____ **Age:** _____ **Gender:** ☐ **Male** ☐ **Female**

Home Tel: _____ **Work Tel:** _____ **Cell:**_____

E-mail: _____

Preferred Contact Method (Check box): ☐ **Home Phone** ☐ **Work Phone** ☐ **Cell Phone**

OK to leave a message on home phone? ☐ **Yes /** ☐ **No** **OK to leave a message on cell phone?** ☐ **Yes /** ☐ **No**

May we contact you by e-mail? ☐ **Yes /** ☐ **No**

May we use your e-mail for medical related correspondence? ☐ **Yes /** ☐ **No**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Other** **Spouse/Partner Name:** _____

Emergency Contact_____ **Phone#**_____

Relationship To You: ☐ **Spouse** ☐ **Family** ☐ **Friend** ☐ **Other:** _____

Reason For Consult/Today's Visit:_____

_____

WORK INFORMATION:

Employer Name: _____ **Occupation:** _____

Employer Address:_____ **Phone#**_____

INSURANCE INFORMATION:

Primary Insurance Carrier:_____**Phone#:**_____

Policy #_____ **Group#**_____

Secondary Insurance Carrier:_____**Phone#:**_____

Policy #_____ **Group#**_____

PRIMARY CARE PHYSICIAN

Name:_____ **Phone#**_____

REFERRAL SOURCE: HOW DID YOU HEAR ABOUT DR. RICHARD J. BROWN, MD

☐ **Website** ☐ **Google** ☐ **Instagram** ☐ **Tik Tok** ☐ **RealSelf** ☐ **Facebook**

Other: _____ **Internet Keywords Used:** _____

Doctor/ Insurance Referral: _____ **Patient Referral:** _____

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Patient Health History

Patient Name: _____ **Height:** _____ **Weight:** _____

HEALTH & FITNESS

Are you Interested in our Nutrition Program? ☐ **Yes** ☐ **No** ☐ **Maybe**

Have you ever worked with a Nutritionist? ☐ **Yes** / ☐ **No**

Do you currently Exercise? ☐ **Yes** / ☐ **No**

If Yes, how many times a week?_____

MEDICAL HISTORY

Past Medical History	Family History	Afflicted Family Member
☐ Denies Past Medical History	☐ No Relevant Family History	
☐ Emphysema	☐ Unknown - Adopted	
☐ Autoimmune Disorders	☐ Autoimmune Disorders	
☐ Asthma	Ex: Lupus, R.A.	
☐ Breast Cancer	☐ Breast Cancer	
☐ Cancer (Other)	☐ Colon Cancer	
☐ Heart Attack	☐ Diabetes	
☐ Diabetes	☐ Glaucoma	
☐ Seizure Disorder	☐ Heart Disease	
☐ Heart Disease	☐ High Blood Pressure	
☐ Heart Murmur	☐ High Cholesterol	
☐ Hepatitis	☐ Liver Disease	
☐ High Blood Pressure	☐ Lung Disease	
☐ Kidney Stones	☐ Malignant Melanoma	
☐ Skin Cancer	☐ Obesity	
☐ Skin Disease	☐ Premature Coronary Heart Disease	
☐ Stroke	☐ Skin Cancer	
☐ Thyroid Disease	☐ Thyroid Disease	
☐ Tuberculosis	☐ Other_____	
☐ Stomach Ulcers	☐ Other_____	
☐ Bleeding Disorder		

Social History

Do you smoke or use nicotine products (gum, patches, vapor, marijuana)? ☐ Yes/ ☐ No If yes, how often:_____

Are you a former smoker? ☐ Yes / ☐ No If yes, when did you stop: _____

Do you drink alcohol? ☐ Yes / ☐ No If yes, how many drinks per week: _____

Pharmacy Information

Pharmacy Name: _____

Cross Streets: _____ and _____

Zip Code: _____ Phone Number: _____

Medications

Are you currently taking any medications or supplements? ☐ Yes / ☐ No

If yes, list medication(s)/supplement(s): _____

_____

Allergies

Are you allergic to any medications? ☐ Yes / ☐ No

If yes, list medication(s): _____

_____

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Past Surgical History

Surgery	Year	Complication (Yes or No)
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Additional Information Regarding Surgical History”

_____

_____

_____

_____

Physician List (If Applicable)

Specialty	Physician Name	Phone Number
1. Referring Doctor		
2. Primary Care Physician		
3. Cardiologist		
4. Hematology/Oncology		
5. Nephrologist		
6. Other		

_____

_____

_____

_____

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Cosmetic Financial Policy

CONSULTATION

Your consultation is designed to meet and discuss your surgical and/or skincare needs, outline procedure and treatment options, and customize a quote for the procedures you have inquired about. These quotes are good for 30 days. Our consultation fee of $175.00 for virtual and $250 for in office is due upfront to schedule your appointment. We require a 2-business day notice for cancelations and appointment changes. If you reschedule your appointment less than 2 days before, there will be a missed appointment fee.

_____

PRE-OPERATIVE TESTING

If any prescription medications, tests, EKG, labs, mammogram, pathology tests, or medical clearance are needed from another physician and found to be medically necessary for your proposed surgery, you will be financially responsible for all costs associated with these tests and/or services.

_____

SURGICAL REVISIONS

I understand and accept that on occasion a revision of my surgery may be necessary. I acknowledge that in such cases fees will apply.

_____

OFFICE SERVICES OR PRODUCTS

For Services and products in the office we accept MasterCard, Visa, American Express, cash, checks, or cashier's checks. Care Credit is only accepted for Cosmetic Surgery.

_____

DEPOSITS AND PAYMENTS

There is a non-refundable fee of $500.00 for booking and scheduling surgery, which is a part of the overall surgical fee. All payments are due in full at your pre-operative appointment or 2 weeks prior to surgery date – whichever date occurs first. All credit cards, cash, checks and cashier's checks are accepted for payment. Should you cancel your surgery without an approved medically acceptable reason, submitted in writing and acceptable to the practice within 2 weeks of your scheduled surgery, the $500 deposit is forfeited. If surgery is canceled within 7 days or less prior to surgery date, patients will forfeit 50% of Surgeon, Facility and Anesthesia fees. **Patients will forfeit 100% of Surgeon, Facility and Anesthesia fees for any surgeries canceled 24 hours prior to surgery date.**

_____

PATHOLOGY

At the time of your surgery, Dr. Brown may remove tissue that he feels should be examined by a laboratory. In that event, you will be responsible for payment of any lab and interpretation fees that are included.

_____

FACILITY AND ANESTHESIA FEES

This quote includes facility and anesthesia fees from the surgery centers that we utilize. These fees may vary depending which date you choose.

_____

ADDITIONAL FEES MAY APPLY:

If surgery extends past the anticipated time Dr. Brown has scheduled, the patient receiving surgery is responsible for all additional fees for Facility & Anesthesia and would be billed post surgery for the additional fees.

_____

_____

_____

_____

(Patient) Print Name Signature Date

(Staff) Print Name Signature Date

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Nicotine Policy

In some cases, complications from long-term nicotine usage may put you at too great a risk to undergo plastic surgery. If you are a nicotine user or have been one in the past, it is critical you notify Dr. Richard J. Brown and get specific clearance before proceeding forward with surgery.

Nicotine use, including but not limited to traditional cigarettes, electronic cigarettes, chewing tobacco, nicotine gum, and nicotine patches, have a direct effect on the outcome of plastic surgery.

Nicotine use increases your risk of surgical complications, including, but not limited to:

- Oxygen Shortage
- Blood Clotting
- Infections
- Skin Necrosis (Loss of Tissue)

In particular the use of nicotine shrinks your blood vessels which in turn restricts the special blood cells needed to travel to the healing areas of your body post-surgery.

In addition, nicotine and other chemicals in cigarettes make your blood more likely to clot, thus clogging capillaries and blood vessels. Unintentional clotting and blood thickening diminish blood flow to and from the operated area.

Plastic surgery procedures often involve reshaping or moving segments of your skin and blood tissue from one area of your body to another. In so doing, a portion of your blood supply to that particular tissue is intentionally severed. Under normal health conditions, your remaining blood supply is more than sufficient for proper healing of your tissue and skin. With nicotine use, however, your body will experience insufficient blood flow preventing your tissue from getting enough oxygen to survive and properly heal. This can often lead to inadequate wound healing or necrosis (severe loss of skin). Thus, it is critical that an adequate blood supply be available at time of surgery and after surgery for proper healing.

In effect, plastic surgery relies on adequate blood supply for proper healing and nicotine use restricts blood supply, which may lead to complications beyond the control of your surgeon.

I have Read and Understand Nicotine Policy for Brown Plastic Surgery:

_____ _____

Patient Print Name Patient Date of Birth

_____ _____

Patient Signature Date

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Nicotine-Related Surgery Requirements

(Please Initial on each line)

_____ As a surgery requirement, I understand and agree to remain nicotine free for at least four weeks prior to and four weeks after my surgery.

_____ I understand that I may be tested for Nicotine at the time of my pre-operative appointment. I agree that if my test is positive, I will be required to reschedule my surgery and I will be charged a $500 rescheduling fee.

_____ I understand that exposure to second-hand smoke can also lead to a positive nicotine test.

_____ I understand that I will be tested for Nicotine on the day of my surgery. **I agree that if my test is positive, my surgery will be cancelled, and all surgeon's fees forfeited. No refunds. No exceptions.**

_____ I understand that if it is determined my nicotine usage has caused the need for additional anesthesia, surgery care, or facility time, I will be charged at a rate of $1500 per hour for the additional time needed.

Regardless of whether I am an active nicotine user at the time I was given a copy of this Nicotine Policy, I fully understand the negative consequences as it relates to nicotine use and plastic surgery. I take full responsibility for any past, present, or future nicotine use. I agree to hold harmless, Dr. Richard J. Brown and anyone associated with Brown Plastic Surgery with regard to complications that may occur as a result of nicotine use. I will not pursue any legal action related to any complications that should occur as a result of nicotine use.

(Please check only one below)

☐ I am NOT an active nicotine user and have NOT been in the past.

☐ I am NOT an active nicotine user, but I have been in the past.

☐ I am an active nicotine user.

_____ _____

Patient Print Name Patient Date of Birth

_____ _____

Patient Signature Date

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Acknowledgment of Receipt of Privacy Notice

I attest the medical information provided is current and accurate to the best of my knowledge. I understand the signed copy of the privacy policy will be placed in my chart indicating that I have read, understood and agree to this policy. A copy of this may be obtained at any time upon your request.

I acknowledge that I have received a copy of the office's **Notice of Privacy Policies.**

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship Date

☐ **Please check here if you would like a copy of our Notice of Privacy Policies**

Statement of Financial Responsibility

I understand that payment for services, whether cosmetic or not, is solely the responsibility of the patient or their guarantor. I hereby authorize Dr. Brown to bill my insurance company or other third parties responsible for my medical charges. I also authorize Dr. Brown to release any medical information that may be requested by my insurance company to help with the process of my claims. I authorize and request that payment be made directly to Dr. Richard J. Brown for all medical and surgical services. I understand that I am responsible for any balance not covered by my insurance company.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship Date

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, siblings or children to call and request/receive medical and/or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical and/or billing information released to a family member you must sign this form. Signing this form will only give consent to release this information to the family members indicated below. This consent form will not allow Richard J. Brown MD to release any other information to these family members. You have the right to revoke this consent at any time in writing.

I authorize/allow Richard J. Brown and/or his staff to release my medical and/or billing information to the following individual(s):

1. Name: _____ Phone: _____ Relationship: _____
2. Name: _____ Phone: _____ Relationship: _____
3. Name: _____ Phone: _____ Relationship: _____

Patient Signature: _____ Date: _____