North Dallas Plastic Surgery

Todd Pollock, M.D.

Date: ________________ Email Address ____

Referred By ____

Patient Name: ____________________________ ________________ ____ ____________________________
Legal First Name | Prefer to be Called | MI | Last Name

Address: ________________________________ ______ __________________________ ______ ________
Street | Apt. | City | State | Zip

Cell: ____________________ Home: (*If Different*)____________________ Work: ____________________ ________ Ext.

SS: _______-____-_______ (*Insurance Only*) Sex: ☐ Female ☐ Male DOB: ___/___/___ Age: ______ Ethnicity: ___________

Occupation: ____ Employer: ____________________________________

Marital Status S M D W *If Applicable*: Spouse/ S.O.: ____

If case of an emergency, contact: ____ Phone: _______________________
Relationship_________________

Responsible Party: Self _____Spouse ______ Parent _____Other_________________________________ ________

PLEASE COMPLETE IF PATIENT IS UNDER 18

Father's Name: ________________________ Phone: ___________________Email:_________________________

Mother's Name: ________________________ Phone:____________________Email:_________________________

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID

Insurance Co. # 1: _______________________ Primary Ins. Holder Name: ____________________________________

Phone ______________________ DOB: ____/____/____ SS #: _____-_____-_____ Relationship: _______________

Insurance Co. # 2: _______________________________ Primary Ins. Holder Name: _______________________________

Phone: ______________________ DOB: ____/____/____ SS #: _____-_____-_____ Relationship: _______________

Payment is due at the time of service. If you have insurance benefits for a procedure, the co-payment and deductible will be collected. Insurance claims will be filed on behalf of the patient for insurance benefits.

RELEASE OF MEDICAL INFORMATION & ASSIGNMENT OF BENEFITS

I authorize NDPS to release any medical information necessary to process my insurance claim and I authorize the payment of my medical benefits to NDPS for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.

X__________________________________Date: ___________
Patient Signature or Responsible Party if Patient is a Minor

I authorize Todd Pollock, M.D. to treat me medically and use my personal health information as necessary.

X________________________________Date: __________
Patient Signature or Responsible Party if Patient is a Minor

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Medical History

Please list the specific concerns or procedure(s) that you would like to discuss. ______________________________

____

Physicians Primary:__________________________ Phone__________________ Last Date Seen__________

Specialist__________________________ Phone __________________ Last Date Seen__________

Allergies List ANY reactions you have had to medications and describe the symptoms.

____

Medications List all prescriptions and dosages, over-the-counter and herbal medications you are taking.

____

____

Medical History List any medical conditions for which you have been treated. **Height**_______ **Weight**________

____

____

____

Women's Health Pregnancies_________ Live Births__________ Miscarriages/Abortions____________

Last Menstrual Cycle ________________________ ☐ Hysterectomy

Mammogram Date____________________ Results: ☐ Normal Other_____________________________

Surgeries List all previous surgeries. Please include **cosmetic surgeries**, and any complications or abnormal reactions to anesthetics.

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____

____

Social History Exercise Habits : ☐ Never ☐ Rarely ☐ Occasionally ☐ Routinely

Cigarette Smoking: ☐ No ☐ Yes ______________ pack(s) per day

Alcohol: ☐ None ☐ Occasional ☐ Moderate ☐ Excessive

Recreational Drug Use: ☐ None Drug:____

Family History CIRCLE any of the following that affect your mother, father, sister or brother.

Anesthetic Problems High Blood Pressure Heart Disease Cancer_______________ Diabetes

Bleeding Disorders Mental Illness Hereditary Disease Other ___________________________

7-13-16KH **M.D. Initials**______________

.North Dallas Plastic Surgery

Systems Review

Please circle any of the following conditions that are ongoing, you have had within the previous 5 years or conditions that it would be of importance for Dr. Pollock to know .

General:	significant weight changes fatigue unexplained fever/chills
Eyes:	eye pain excessive tearing visual changes double vision eye irritation dry eyes
	red eyes glaucoma contact lenses sensitivity to light
Ears:	ear pain ringing in the ears dizziness hearing loss
Nose:	nasal trauma nasal surgery difficulty breathing through nose sinus problems
Mouth:	dental problems tooth pain difficulty swallowing oral cancers dentures capped teeth
Cardiovascular:	high blood pressure heart attack heart surgery irregular heartbeat murmur
	chest pain congestive heart failure foot swelling rheumatic fever pacemaker
Respiratory:	asthma shortness of breath bronchitis pneumonia recent cough TB
Gastrointestinal:	peptic ulcers reflux indigestion vomiting diarrhea constipation bloody stools
	black stools change in bowel habits hepatitis: A B C jaundice liver cirrhosis
Genitourinary:	urinary tract infections yeast infections difficulty urinating frequent urination STD
Musculoskeletal:	injuries swelling extremity pain joint pain arthritis leg cramps difficulty walking
Neurologic:	seizures stroke dizziness sensory loss weakness numbness
Psychiatric:	depression alcoholism drug abuse anxiety marital problems
Hematologic:	bleeding disorders anemia easy bruising bleeding gums swollen lymph nodes
Immunologic:	HIV high risk behavior blood transfusions autoimmune disease
Endocrine:	diabetes thyroid disorder hypoglycemia adrenal disorders
Skin Disease:	rashes new or changing lesions skin cancers alopecia
Drugs:	diet aides aspirin herbal blood "thinners" steroids chemotherapy
Allergic:	food allergies environmental adhesive or band-aid sensitivity latex allergy

Please provide specific symptoms if you selected latex allergy :

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____

KH7-15-16   MD Initials__________

North Dallas Plastic Surgery

In our efforts to comply with the health information privacy act, HIPAA, we will guard your privacy according to your wishes.

<u>Please circle your response to the following</u>:

May we leave messages on your cell phone?		Yes	No
May we leave messages on your home phone?	N/A	Yes	No
May we send you emails regarding your healthcare?		Yes	No
May we leave information with a spouse or significant other?		Yes	No
Is there anyone else with whom we may discuss your medical care? If "Yes, please specify.		Yes	No

____________________________________ ______________________
Name Phone

____________________________________ ______________________
Name Phone

You must inform us, in writing, of any changes in your directives. This record takes effect April 14, 2003 and will be kept in your file along with your acknowledgment of receipt of our Notice of Privacy Practices.

Signature: ____ Date: ____________

Print Name: ____

Receipt of Notice of Privacy Practices Written Acknowledgment Form

I have reviewed and have been offered the N.D.P.S. Practice Privacy Guidelines.

____ Date_______________
Signature

DISCLOSURE: *Dr.Todd Pollock has ownership interest in The Texas Institute for Surgery at Presbyterian Hospital of Dallas. Therefore, he may derive financially from surgery being performed there. Please let us know if this is of concern to you.*

Notice of Privacy Practices

North Dallas Plastic Surgery Associates

8305 Walnut Hill Lane, Suite 210
Dallas, Texas 75231
214-363-2575

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI, which is information about you, including demographics'-that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, paying your health care bills, supporting the operation of our practice, and any other use as required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party such as a physician to whom you have been referred, an anesthesia provider, or a home health care agency.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to your health plan.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of our practice, such as quality assessment, employee review, physician training, licensing, and conducting or arranging for other business activities. For example, we may call you by name in the waiting room. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI, without your authorization, in the following situations: As Required By Law, Health Oversight, Research, Public Health Issues, Communicable Diseases, Abuse or Neglect, FDA Requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Criminal Activity, Military Duty, National Security, Workers' Compensation, Inmates and any other required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with Section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object, unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to inspect and copy your PHI. However, under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in anticipation of or use in a civil, criminal, or administrative action or proceeding; and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PH I not be disclosed to family or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, it will not be restricted. You then have the right to use another physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us.

You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you a copy.

You have the right to receive an accounting of certain disclosures we have made of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint by notifying our Privacy Officer. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of PHI and provide individuals with this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this notice, please ask to speak with our Privacy Officer. This notice became effective on April 14, 2003.