North Dallas Plastic Surgery

Todd Pollock, M.D.

Date: _____ Email Address_____

Referral_____

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: _____-____-_____ Sex: ☐ Female ☐ Male DOB: ___/___/___ Age: _____ Ethnicity: _____

(Insurance Only)

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.

RELEASE OF MEDICAL INFORMATION, BENIFIT ASSIGNMENT & DISCLOSURE

I authorize Todd Pollock, M.D. to medically treat me, using my personal health information as needed, and I authorize NDPS to release any medical information necessary to process my insurance claim. NDPS may receive payment from my insurance carrier for services rendered, if a covered procedure. I understand that I am financially responsible for any services determined to be cosmetic or not a covered benefit under my insurance plan. _____ (Initial)

I understand that matters involving payment and/ or a payment dispute, including but not limited to, issues involving finance companies, credit card companies and financial institutions, my personal health information may be disclosed. _____ (Initial)

Todd Pollock, M.D. has ownership interest in The Texas Institute of Surgery at Presbyterian Hospital of Dallas. Therefore, he may financially benefit from surgery performed there. Please let us know if this is of concern to you. _____ (Initial)

_____Date: _____

Patient Signature or Responsible Party if Patient is a Minor

North Dallas Plastic Surgery
Medical History

Please tell us what brings you in to see Dr. Pollock today:_____

_____

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 _____ lbs

_____

_____

_____

Women's Health Total # of 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.

_____

_____

_____

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 _____

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 :

_____

_____

North Dallas Plastic Surgery

Communication & Personal Health Information

It is the goal of NDPS to communicate with you expeditiously, conveniently and at your acceptable level of risk. This form will provide us with your communication preferences.

One of the purposes of The Health Insurance Portability and Accountability Act (HIPAA) is protecting the privacy of your health information (PHI) and the security of electronic records. Communications via email or text messages are a popular, convenient and quick form of communication, but there is a level of risk that the information could be intercepted by a third party. Therefore, email and text transmissions are considered unsecure forms of communication. Emails can be made secure by encryption; however, at this time NDPS does not have an encrypted email server. Therefore, email communication does bear some risk.

I understand the risks of receiving unencrypted emails and I authorize Todd Pollock, MD or any of his designees to email me my personal health information, including photographs, unencrypted.

_____ _____ _____

Signature Date Printed Name

_____

Please print the email address in which you would like to correspond.

Please initial your responses:

NDPS may leave messages on my cell phone. _____ Yes: Cell Number_____ _____ No

NDPS may send me text messages. _____ Yes: Cell Number_____ _____ No

NDPS may leave messages on my home phone. ____ N/A _____ Yes: Home Number_____ _____ No

NDPS may leave information with a spouse or significant other? _____ Yes: Name_____ _____ No

Phone Number: _____

Please list anyone else with whom we may share your medical information.

_____ _____ _____

Name Relationship Cell Number

_____ _____ _____

Name Relationship Cell Number

You must inform us, in writing, of any changes in your directives. This record took effect April 14, 2003 and will be kept in your file along with your acknowledgment that you have reviewed the N.D.P.S. Notice of Privacy Practices.

Signature:_____ Date:_____ Print Name:_____

Todd Pollock, M.D.
8305 Walnut Hill Lane; Suite 210
Dallas, Texas 75231