C

Patient Information Form

Today's Date: ___________________

First Name: ____________________________________ **M.I.:** _________ **Last Name:** __________________________

Address: _____________________________________**City:**____________________**State:**_______**Zip:**____________

SS#: ____________________ **Date of Birth:** _________________ **Age:** ___________ **Gender:** **Male** **Female**

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

Home Tel: _____________________ **Work Tel:** _____________________ **Mobile Tel:**__________________________

E-mail: ____ **May we contact you by e-mail?** **Yes / No**

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

Preferred Contact Method (Circle): **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**

Employer Name: _________________________ **Occupation:** ____

Address: ____ **Work Phone:** ________________________________

Reason For Visit: ____

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

Website ☐ **Google** ☐ **RealSelf** ☐ **Yelp** ☐ **Facebook** ☐ **Instagram** ☐

Other Website: ________________________________ **Internet Keywords Used:** ________________________________

Doctor/ Insurance Referral: _________________________ **Patient Referral:** _______________________________________

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: __________________________

Scottsdale: 11000 N. Scottsdale Rd. Ste 100 Scottsdale, AZ 85254
Sun City: 13640 N. 99th Ave. Ste 400 Sun City, AZ 85351
Phone: 480.947.2455 **Fax:** 480.947.2456 **Web:** www.richardjbrownmd.com

Patient Health History

Patient Name: ____ **Height:** _______________ **Weight:** ____________

Past Medical History	Family History	Afflicted Family Member
☐ Denies Past Medical History	☐ No Relevant Family History	
☐ Emphysema	☐ Unknown - Adopted	
☐ Asthma	☐ Autoimmune Disorders	
☐ 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: ______________________________________

Allergies/ Medications

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

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

____

____

Are you allergic to any medications? Yes / No

If yes, list medication(s):

____

____

Past Surgical History

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

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		

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 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, this fee is forfeited. While this may appear to be a charge for services which were not provided, this fee is necessary to reserve time in the operating room and in the practice, which are done when you schedule.

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.

____ ______________________

Signature Date

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