# CARMEL COSMETIC AND PLASTIC SURGEONS

ELIZABETH GRASEE, M.D. DEBRA BERGMAN, M.D.

DATE:_____

NAME_____ SEX:_____
LAST FIRST MI

ADDRESS_____
STREET CITY STATE ZIP

HOME PHONE _____DATE OF BIRTH_____ SS#_____
CELL PHONE_____E-MAIL_____
[ ] MARRIED [ ] SINGLE [ ] SEPARATED [ ] DIVORCED [ ] WIDOWED NAME OF SPOUSE_____

HOW WERE YOU REFERRED TO US? HOW DID YOU BECOME AWARE OF US? (CHECK ALL THAT APPLY)
[ ] PHYSICIAN NAME_____ [ ] FRIEND NAME_____ [ ] WEBSITE
[ ] YELLOW PAGES [ ] OTHER_____

REASON FOR SEEING PHYSICIAN_____

PATIENT OCCUPATION_____

EMPLOYER'S NAME_____

EMPLOYER'S ADDRESS_____
STREET CITY ST ZIP
EMPLOYER'S PHONE_____EXT_____

IN CASE OF EMERGENCY, PLEASE LIST NAME, PHONE NUMBER, AND RELATIONSHIP OF PERSON(S) TO CONTACT:

NAME _____ RELATIONSHIP_____ PHONE_____

NAME_____ RELATIONSHIP_____ PHONE_____

FAMILY PHYSICIAN (PC)_____ PHONE_____

ADDRESS_____
STREET CITY ST ZIP

WITH YOUR PERMISSION, WE WOULD LIKE TO NOTIFY YOUR FAMILY PHYSICIAN OF YOUR VISIT: [ ] YES [ ] NO

INSURANCE INFORMATION: IN ORDER TO ASSIST YOU IN THE SOMETIMES DIFFICULT AND TIME CONSUMING TASK OF COMPLETING MEDICAL INSURANCE FORMS, WE NEED THE FOLLOWING COMPLETED IN ITS ENTIRETY. IN ADDITION TO THIS FORM, PLEASE HAVE YOUR INSURANCE CARD OUT FOR THE RECEPTIONIST TO COPY. THANK YOU.

PRIMARY INSURANCE: (IF MORE THAN ONE INSURANCE, COMPLETE SECONDARY INSURANCE INFORMATION)
INSURANCE COMPANY_____POLICY HOLDER'S DATE OF BIRTH_____
INSURANCE COMPANY ADDRESS_____
POLICY HOLDER_____SOC SEC#_____RELATIONSHIP TO PT_____
POLICY NUMBER_____GROUP#_____EMPLOYER_____PHONE_____

SECONDARY INSURANCE
INSURANCE COMPANY_____POLICY HOLDER'S DATE OF BIRTH_____
INSURANCE COMPANY ADDRESS_____
POLICY HOLDER_____ SOC SEC# _____RELATION TO PT_____
POLICY NUMBER_____GROUP #_____ EMPLOYER_____PHONE_____

## *PLEASE SIGN AUTHORIZATION STATEMENT ON BACK*

**PLEASE SIGN BELOW:**

*I acknowledge I am financially responsible for any services rendered by Dr. Grasee/Dr. Bergman.*

*I authorize Carmel Cosmetic & Plastic Surgeon to use pre and post operative photographs taken of me in connection with medical or cosmetic services I receive from them for educational and medical practice purposes. I understand that Carmel Cosmetic & Plastic Surgeons will not identify me by name when using such photographs.*

SIGNATURE (if child, responsible party)_____

DATE_____

**PLEASE SIGN BELOW IF YOU WANT OUR OFFICE TO FILE WITH YOUR INSURANCE COMPANY**

**MEDICAL INSURANCE RELEASE**

*I authorize the release of medical information including photographs necessary to process any claim for services provided by Dr. Grasee / Dr. Bergman. I further authorize the release of medical benefits to Carmel Cosmetic & Plastic Surgeons. A copy of this authorization may be used in place of the original. I understand the physician's charges may exceed my insurance carrier's allowable payment, and if this should occur, I realize I will be responsible for that portion.*

SIGNATURE (if child, responsible party)_____

DATE_____

**MEDICARE PATIENTS**

MEDICARE NOW REQUIRES US TO HAVE EACH OF OUR MEDICARE PATIENTS SIGN A ONE-TIME PAYMENT AUTHORIZATION. THANK YOU FOR YOUR COOPERATION.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE MEDIGAP BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO CARMEL COSMETIC AND PLASTIC SURGEONS FOR ANY SERVICES FURNISHED TO ME BY THAT PRACTICE. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFIT PAYMENT FOR RELATED SERVICES.

PLEASE SIGN_____

DATE_____

# CARMEL COSMETIC AND PLASTIC SURGEONS

MEDICAL HISTORY FORM

**Confidential record: Information contained here will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your doctor in making decisions regarding your care.**

NAME_____ DATE _____
LAST FIRST MIDDLE

AGE_____ HEIGHT_____ WEIGHT_____ DOB_____

| DRUG ALLERGIES: | REACTION: | DRUG ALLERGIES: | REACTION: |
|---|---|---|---|
| 1. _____ | _____ | 4. _____ | _____ |
| 2. _____ | _____ | 5. _____ | _____ |
| 3. _____ | _____ | 6. _____ | _____ |

**PHARMACY NAME:**_____ **PHONE NUMBER:**_____

**CURRENT MEDICATIONS AND DOSAGES:**

1. _____ 8. _____
2. _____ 9. _____
3. _____ 10. _____
4. _____ 11. _____
5. _____ 12. _____
6. _____ 13. _____
7. _____ 14. _____

DO YOU TAKE ASPIRIN OR BLOOD THINNERS REGULARLY? [] YES [] NO _____

**SURGERIES AND DATES:**

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

**MEDICAL CONDITIONS:**
DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | HIGH BLOOD PRESSURE | ☐ | ☐ | MIGRAINE | ☐ | ☐ | COLITIS |
| ☐ | ☐ | DIABETES | ☐ | ☐ | EPILEPSY / SEIZURES | ☐ | ☐ | ARTHRITIS |
| ☐ | ☐ | HEART ATTACK / ANGINA | ☐ | ☐ | BRONCHITIS | ☐ | ☐ | KIDNEY DISEASE |
| ☐ | ☐ | HEART FAILURE | ☐ | ☐ | ASTHMA | ☐ | ☐ | BLADDER INFECTION (UTI) |
| ☐ | ☐ | ARRYTHMIA | ☐ | ☐ | PNEUMONIA | ☐ | ☐ | THYROID DISEASE |
| ☐ | ☐ | CONGENITAL HEART DISEASE | ☐ | ☐ | TUBERCULOSIS | ☐ | ☐ | BLEEDING DISORDERS |
| ☐ | ☐ | STROKE | ☐ | ☐ | TONSILITIS | ☐ | ☐ | HIV / AIDS |
| ☐ | ☐ | CANCER | ☐ | ☐ | STOMACH ULCER | ☐ | ☐ | COLD SORE |
| ☐ | ☐ | LEUKEMIA/LYMPHOMA | ☐ | ☐ | HEPATITIS | ☐ | ☐ | MRSA |

OTHER MEDICAL CONDITIONS:_____

PSYCHIATRIC DISORDERS:_____

SIGNATURE: _____ DATE: _____

**DATE UPDATED AND INITIALS:**

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

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NAME_____ DATE _____
LAST FIRST MIDDLE

**FAMILY HISTORY:**

DOES ANY FAMILY MEMBER HAVE A HISTORY OF ANY OF THE AFOREMENTIONED CONDITIONS?_____
IF YES, PLEASE SPECIFY:

_____

_____

**SOCIAL HISTORY:**

HAVE YOU EVER SMOKED OR EVER VAPED? [] YES [] NO If yes, please specify amount:_____ Date Quit:_____

DO YOU REGULARLY DRINK ALCOHOL? [] YES [] NO If yes, please specify amount:_____

**BREAST HISTORY:**

DATE OF LAST MAMMOGRAM:_____ WHERE DONE? _____ RESULT: _____

DATE OF LAST BREAST MRI: _____ WHERE DONE? _____ RESULT: _____

DO YOU HAVE A HISTORY OF BREAST CANCER?_____ [] LEFT BREAST [] RIGHT BREAST

BREAST SURGICAL PROCEDUES INCLUDING BIOPSIES: _____

_____

DATE OF LAST CHEMOTHERPHY: _____ ONCOLOGIST:_____

DATE OF LAST RADIATION TREATMENT: _____ RADIATION ONCOLOGIST: _____

FAMILY HISTORY OF BREAST CANCER? Please specify relationship to you and age at diagnosis:_____

_____

NUMBER OF PREGNANCIES?_____ PLEASE LIST ANY COMPLICATIONS DURING PREGNANCY:_____

_____

NUMBER OF LIVE BIRTHS: _____ DID YOU NURSE?_____ NUMBER OF CHILDREN BREASTFED:_____

SIGNATURE:_____ DATE:_____

**DATE UPDATED AND INITIALS:**

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

# CARMEL COSMETIC AND PLASTIC SURGEONS

ELIZABETH GRASEE, M.D. DEBRA BERGMAN, M.D.

MEDICAL HISTORY FORM
Carmel, IN 46032
Phone: 317-581-0001
Fax: 317-581-0002

## PRIVACY POLICY

I have received the Notice of Privacy Practices for Protected Health Information and understand that my protected health may be used by Carmel Cosmetic and Plastic Surgeons as described in the notice.

Patient Name (please print)_____

Patient Signature_____Date_____

**********

## SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION

With whom may we speak regarding your care and/or account?

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

***For additional names, please use the back of this form***

May we:

| | | |
|---|---|---|
| Leave a detailed message on your voice mail at home? | ____yes | ____no |
| Leave a detailed message on your voice mail at work? | ____yes | ____no |
| Leave a detailed message on your cellular voice mail? | ____yes | ____no |
| Leave a detailed message with whomever answers the phone at home? | ____yes | ____no |
| Send you a detailed message via e-mail? | ____yes | ____no |
| Send you a Carmel and Cosmetic Surgeons Newsletter to you via e-mail? | ____yes | ____no |

A detailed message would typically consist of the practice name and/or your physician's name, as well as containing specific information pertaining to you or requested by you. It may also contain questions we need you to answer.