MILE HIGH plastic surgery

Aura ADVANCED SKIN CARE & PLASTIC SURGERY

PATIENT REGISTRATION

Co-Pay_____

Patient Last Name _____ First Name _____ Middle Initial _____

SSN _____ Date of Birth _____ Sex: M/F

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____Work Phone _____

E-mail _____ Preferred number to call: Home/Cell/Work

Preferred method of contact: Phone/ Text/ E-mail

Emergency Contact: _____ Relationship _____

Contact Phone Number _____

Employer Name _____ Occupation _____

Address _____ City _____ State _____ Zip Code_____

Primary Care Physician _____

Referring Physician _____

Is this appointment work or auto related?

If yes, claim # _____ Insurance Co _____

Phone number _____ Contact person _____

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Primary Insurance:

Insurance Name _____ Referral Needed? Yes/No

Member ID _____ Group # _____ Phone _____

Policy holder if different from patient _____ Relationship_____

Date of Birth _____ SSN _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Secondary Insurance:

Insurance Name _____ Referral Needed? Yes/No

Member ID _____ Group # _____ Phone _____

Policy holder if different from patient _____ Relationship_____

Date of Birth _____ SSN _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Authorization and Release

I hereby authorize Nathan Roesner, D.O. and providers of Mile High Plastic Surgery to treat the patient identified above. I acknowledge that I am responsible to pay all charges for any treatments administered by the physician to the patient. I understand that insurance may not pay for all charges and I understand that I am obligated to pay for all charges not covered by insurance. I also agree to pay reasonable attorney fees if my account is turned over to an attorney or collection agency.

Signature of Patient/Authorized Person _____ Date _____

Assignment and Release

I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims.

Signature of Patient/Authorized Person _____ Date _____

Would you like to receive emails for Special Events or Discounts? Yes/No

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PATIENT HIPPA QUESTIONAIRE

Please list the family members or significant others, if any, whom we may inform about your medical condition: ONLY IN AN EMERGENCY.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home address.

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL": Yes ____ No ____

Please print the telephone number where you want to receive calls about your appointments, lab, and radiology results, or other health care information if other than your home phone number:

( )_____

I am fully aware that a cell phone is not a secure and private line

I am fully aware my health information can be transmitted by facsimile (fax, mail or the internet)

Can confidential messages (i.e. appointment reminders) be left on your home answering machine or voicemail? Yes___ No___

Patient/Guardian Name_____ Date _____

Patient/Guardian Signature _____

PATIENT SIGNATURE SECTION:

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the attached (above) Notice of Privacy Practices ("The Notice") for the practice of Mile High Plastic Surgery, LLC.

Patient/Guardian Name _____ Date_____

Patient/Guardian Signature _____

**If patient representative/guardian, legal documentation must be included to show authority to sign or receive information.

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PATIENT MEDICAL HISTORY INFORMATION

Last Name _____ First Name _____ Date of Birth _____

To avoid duplication, on the day of testing, please bring: any recent lab reports, chest X-ray report from a radiologist, and/or ECG with an internist or cardiologist report. For questions, please call 303-909-6977

A. To your knowledge, do now have or have you ever had any of the following?

	Yes	No		Yes	No		Yes	No
Anemia			Mental Health Disorder (If yes, please specify below)			Cardiac or Irregular Heartbeat		
Autoimmune Disease (if yes, please specify below)			Clotting disorder or history of blood clots			Cancer (if yes, please specify below)		
Diabetes			Hypertension (high blood pressure)			Stomach ulcer		
Do you take predental antibiotics?			Thyroid disease			Hyperlipidemia (high cholesterol)		
Seizures			Stroke			Previous reaction to Anesthesia (if yes, please specify below)		
Childbirth			Asthma/Respiratory Disorders			Sleep Apnea		

Additional Medical History not listed above:_____

_____

_____

B. Please list all previous surgeries.

Date (or approximate year)	Surgery	Place (Hospital or City)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

C. Please list all prescription medication, over-the-counter medications, vitamins and supplements. Please include dosage and frequency.

Medication	**Dose**	**Frequency**

D. Please list all drug and food allergies, including reaction(s).

_____

_____

E. 1) Do you or have you ever used tobacco products (cigarettes, cigars, pipe, chew)? Yes/No
Number of packs/cigars per day _____ Number of years _____ Quit date _____

2) Do you drink alcoholic beverages? Yes/No
If yes, how much do you typically drink in a week _____

3) Do you use any illicit or recreational drugs (including marijuana)? Yes/No
If yes, please specify: _____

F. Family History

Please check any disease/conditions that run in your family. Please indicate the family member.

	Yes	No		Yes	No		Yes	No
Heart Attack			Cancer			Diabetes		
Stroke			Heart Disease			Auto Immune Disease		
Clotting Disorder								

G. Size information (If applicable)

Height: _____ Weight: _____

Bra size: _____ Pant size: _____

H. Do you have any special concerns?

_____

_____

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Circle what services you are interested in:

Aesthetic Procedures	**Surgery Procedures**
Botox/Dermal Fillers	Vaser Lipo (Liposuction)
Coolsculpting	Rhinoplasty
Laser Resurfacing (CO2, Halo, Pearl)	Eyelid Surgery (Blepharoplasty)
Dermaplane	Ear Surgery (Otoplasty)
Microdermabrasion	Full Body Lift
Chemical Peels	Breast Augmentation
Laser Hair Removal	Neck lift
Laser Vein Therapy	Tummy Tuck
Lash and Brow Waxing/Tinting	Fat Transfer
Photofacial (IPL, BBL)	Mommy Makeover
MicroNeedling	Breast Reconstruction
Vivace RF Microneedling	Arm Lift
Laser Genesis	Thigh Lift
Advanced Acne Treatment	Face Lift

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Progress Note