Susan J. Dean, MD, *Board Certified Plastic Surgeon*

2490 South Woodworth Loop
Suite 310, Palmer, AK 99645
907.745.7575 phone 907.745.7570 fax

www.matsuplasticsurgery.com

PATIENT REGISTRATION FORM

Name:

_____
Last *First* *MI*

Address: _____
Street *City* *State* *Zip*

Prefix: Mr. / Ms. / Mrs. / Dr. Suffix_____ Preferred

Name_____

Date of Birth: ___/___/___ Gender: M / F SSN: _____ Marital Status _____

Home Phone: (_____) _____Work Phone: (____) _____Ext. _____

Cell Phone: (_____) _____ Personal Email address: _____

PARENT OR GUARDIAN OF PATIENT UNDER 18 YEARS OF AGE

Name: _____ Date of Birth: ____/_____/_____ Phone: (____) _____

Address: _____
Street *City* *State* *Zip*

PRIMARY INSURANCE INFORMATION

Policyholder: _____Relationship to patient: _____

Date of Birth: _____SSN:_____Daytime phone # :(_____) _____

Address: _____
Street *City* *State* *Zip*

SECONDARY INSURANCE INFORMATION

Policyholder: _____Relationship to patient: _____

Date of Birth: _____SSN:_____Daytime phone # :(_____) _____

Address: _____
Street *City* *State* *Zip*

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EMERGENCY CONTACT INFORMATION

Emergency Contact _____Relationship to patient: _____

Phone #1: (_____) _____ Phone #2: (_____) _____

PATIENT EMPLOYMENT INFORMATION

Employment status: Employed / Student / Self-employed / Retired Company: _____

PHYSICIAN REFERRAL INFORMATION

Referred by: _____Practice Name _____

PHARMACY INFORMATION

Preferred Pharmacy and Street Address:

_____

HOW DID YOU HEAR ABOUT US?

Physician Family Friend Yellow Pages Insurance Carrier Internet Newspaper Ad Other

MEDICAL HISTORY

Reason for visit _____

_____

Allergies: **NONE** (please list any drugs and type of allergic reaction)

_____ _____ _____

_____ _____ _____

Current Medications: **NONE** (include herbal supplements, vitamins and/or over the counter medications)

_____ _____ _____

_____ _____ _____

Pregnancy: Are you pregnant? _____ Breastfeeding? _____ Are you planning a pregnancy in the future? _____

Medical History: **NONE** Please list any current or past medical conditions:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you ever had tuberculosis or have you recently been exposed to tuberculosis? _____

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Family Medical History: **NONE** Please list any current or past medical conditions of immediate family members:

_____ _____ _____
_____ _____ _____

Social History: Occupation:

_____

Alcohol use (list per week) _____Tobacco use (list packs per day)_____

Major Surgeries: **NONE**

_____ Date _____ _____Date_____
_____ Date _____ _____Date_____
_____ Date _____ _____Date_____

Major Hospitalizations: **NONE**

_____ Date _____ _____Date_____
_____ Date _____ _____Date_____

Do you have any of the following? Please circle any positive answers

_____ Chills, fatigue, fever, weight gain or weight loss
_____ Blurred vision, sensitivity to light
_____ Rapid heart beat, feet and leg swelling, varicose veins
_____ Genital lesions
_____ Joint aches, muscle aches, joint stiffness
_____ Itching, sensitivity to light, rash
_____ Weakness, dizziness, tingling, loss of skin sensation
_____ Easy bruising, excessive bleeding
_____ Hair loss, excessive hair growth, dark color in skin, stretch marks, excessive sweating
_____ Seasonal allergies, hives
_____ Depression, Suicidal thoughts

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AUTHORIZATION TO DISCLOSE HEALTH OR BILLING INFORMATION

We will communicate with your referring physician. Are there any other physicians, family members or friends with whom you would like us to share your information?

Name	Contact Information
Name	Contact Information
Name	Contact Information
Name	Contact Information

I request that Mat-Su Plastic Surgery make my medical information available to the above with the following restrictions:

Any ☐ List restrictions:

No Restrictions ☐

Patient Name	Signature	Date

1. By law, Mat-Su Plastic Surgery cannot use or share my health information without my permission except by ways listed in Mat-Su Plastic Surgery's Notice of Privacy Practices.
2. I can cancel this authorization at any time. I must cancel in writing and address it to the person or organization named above. I cannot cancel consent for information already shared as a result of this permission.
3. I do not have to sign this form. Refusal won't change my ability to get treatment, payment for treatment or benefits.
4. Once information is sent, it may not be protected by law and someone may be able to share my information with others without my permission.
5. I have read, understand and been given a copy of this form.
6. No Protected Health Information will be used for marketing or research.

NOTICE: I may be charged to copy or mail this information.