southpoint
PLASTIC SURGERY

Name: (First) _____ (Middle) _____ (Last) _____

Today's Date: _____ Date of Birth: _____ Age: _____ Gender: _____

Address: _____ Zip Code: _____

Phone (cell) : _____ (home): _____ (work): _____

Do you consent for us to leave you voicemails on the phone numbers you provided? □ Yes □ No

Do you consent for us to leave a message with another person if they answer your phone? □ Yes □ No

Preferred Method of Contact: □ Cell Phone □ Home Phone □ Work Phone □ E-mail

E-mail Address: _____

Would you like us to send you exclusive offers and private event information via e-mail? □ **Yes!** □ No

EMERGENCY CONTACT

Name: (First) _____ (Last) _____ Relationship: _____

Phone (cell) : _____ (home): _____ (work): _____

Address: _____ Zip Code: _____

REFERRAL INFORMATION

□ Doctor Referral _____ □ Google □ Facebook □ Instagram

□ Patient Referral _____ □ RealSelf □ Twitter □ Radio

□ Local Business _____ □ Other _____

EMPLOYMENT INFORMATION

☐ Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Military ☐ Healthcare Professional ☐ Other: _____

INSURANCE INFORMATION

Primary Insurance Company Name:_____ Tel: _____

Are you the primary holder? □ Yes □ No What is the primary holder's relationship to you? _____

Name of Primary Holder: (First) _____ (M.I.) _____ (Last) _____

Primary holder's social security #: _____ Your social security #_____

Policy #:_____ Group #: _____ Specialist Co-pay? ☐ No ☐ Yes, $_____

I understand that office visit charges are payable on the day service is rendered. I authorize Duncan Hughes MD to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Duncan Hughes MD and myself.

Signature: _____ **Date:**_____

MEDICAL HISTORY

Weight:_____ **Height:** _____

Current Medications: (please indicate dosage)

_____

_____

_____

_____

Have you taken Accutane within the past twelve months? ☐ Yes | ☐ No

Is there a possibility you may be pregnant? ☐ Yes | ☐ No

Allergies/Sensitivities: (ex: medications, soaps, anesthetics, latex, seafood, nuts)

_____

_____

_____

Past surgeries: (include dates and hospitals)

_____

_____

_____

Do you have a history of or do you currently have?

□ High Blood Pressure	□ Diabetes	□ HIV or AIDS	□ Asthma	□ Heart Disease
□ Kidney Disease	□ Latex Allergy	□ Stroke	□ Heart Failure	□ Tumors
□ Psychiatric Diagnosis	□ Hepatitis	□ Chest Pain	□ Gastric Reflux	□ Arthritis
□ Bleeding Problems	□ Emphysema	□ Heart Attack	□ Liver Disease	□ Seizures
□ Ulcers	□ Pacemaker or defibrillator		□ Cancer_____	

Do you have a personal or family history of anesthetic complications or malignant hypothermia?
If yes, please explain. _____

Are you under the care of a psychiatrist/psychologist? ☐ No | ☐ Yes, for _____

Any other medical concerns we should know about?

_____

_____

_____

_____

_____

_____

Lifestyle [Please indicate how often]

☐ Tobacco _____/day ☐ Caffeine _____/day ☐ Alcohol _____/day ☐ Water _____/day

Notice of Privacy Practices
By signing below, I acknowledge that I was offered a copy of the *Notice of Privacy Practices*. Any questions regarding this notice were answered to my satisfaction.
Please initial all that apply.

_____ I read and understood the provided *Notice of Privacy Practices*.
_____ I would like a copy of the *Notice of Privacy Practices*.

Patient Signature: _____Date: _____

Scheduling Policy
Our goal is to provide quality, individualized care. Due to the customized nature of our practice, appointments are in high demand; we highly recommend making reservations in advance for our services. We will always do our best to accommodate your scheduling needs. Our policy enables us to better utilize available appointments for all of our clients. _____**(initial)**

Cancellation of an Appointment
In order to be respectful of the needs of every patient, please call us promptly if you are unable to show up for an appointment. No-shows and late cancellations inconvenience individuals like yourself who appreciate access to treatments in a timely manner, as well as the provider.
If it is necessary to cancel your scheduled appointment, we require that you call at least 24 business day hours in advance. This courtesy enables us to compensate our employees for their time, and maintain a greater availability of our time for you as well as others. _____**(initial)**

How to Cancel Your Appointment
To cancel appointments, please call 919-806-8866. If you do not reach the Practice Concierge, please leave a detailed message or send an email to info@southpointplasticsurgery.com. If you would like to reschedule your appointment, please indicate that in your message. We will return your message and give you the next available appointment time. _____**(initial)**

Late Cancellations
A late cancellation is considered when a patient fails to cancel or reschedule their appointment with a 24-hour business day advance notice.

- Each late cancellation will result in a $50 fee. _____**(initial)**

No Show Policy
A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show."

- Each no-show will result in a $50 fee. _____**(initial)**

Late Arrival
Late arrivals will not receive an extension of scheduled service times and will be responsible for full service fees. _____**(initial)**

I understand and agree to the scheduling policy above.

Patient Signature: _____Date: _____

PHOTO CONSENT & RELEASE FORM

I, the undersigned, do hereby agree to the following: I am allowing a Southpoint Plastic Surgery staff member to take photos of my treatment and/or treated areas to be used for the purpose of monitoring my progress in my medical chart.

In addition:

I give permission for my photos to be used for education. _____ (please initial)

I give permission for my photos to be used for advertising. _____ (please initial)

I understand that my identity will remain anonymous. _____ (please initial)

Print name: _____

Signature: _____ Date: _____