LYOS
PLASTIC SURGERY & ASSOCIATES

New Patient Forms

DATE _____ HOW WERE YOU REFERRED?_____

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ MI_____

DATE OF BIRTH _____ SSN_____ AGE_____ SEX_____

HOME ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE #_____ CELL PHONE #_____

EMAIL ADDRESS_____

RELATIONSHIP STATUS (circle one) S M D W

PREFERRED CONTACT (circle one) HOME CELL WORK EMAIL

EMPLOYMENT INFORMATION

OCCUPATION _____ WORK #_____

EMPLOYER_____

PHARMACY

NAME/LOCATION _____ PHONE #_____

EMERGENCY CONTACT

NAME _____ RELATIONSHIP_____

HOME PHONE_____ WORK_____ CELL_____

REASON FOR VISIT: _____

_____

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HEALTH HISTORY FORM

Patient Name: _____ DOB: _____

Please answer all of the questions as accurately as possible. If you do not understand a question please ask for assistance.

Primary Care Doctor: _____

Smoker? If so type & amount per day _____ Alcohol (type and amount per week) _____

If former smoker, quit date: _____ Weight _____ Height _____

Drug/Food Allergies: _____

List previous surgeries or major illnesses and dates: _____

_____

_____

_____

List any medications you are taking including non-prescription drugs, vitamins, and herbals: _____

_____

FAMILY HISTORY

Has any blood relative ever had the following:

BREAST CANCER.....	no	yes	HIGH BLOOD PRESSURE.....	no	yes	KIDNEY DISEASE.....	no	yes
MELANOMA.....	no	yes	HEART DISEASE.....	no	yes	DEPRESSION.....	no	yes
STROKE.....	no	yes	DIABETES.....	no	yes			

PAST MEDICAL HISTORY

STAPH/SKIN INFECTIONS.....	no	yes	CANCER.....	no	yes	STOMACH ULCER.....	no	yes
HEART DISEASE.....	no	yes	GLAUCOMA.....	no	yes	KIDNEY DISEASE.....	no	yes
ARTHRITIS.....	no	yes	ASTHMA.....	no	yes	THYROID DISEASE.....	no	yes
RHEUMATIC FEVER.....	no	yes	AIDS or HIV+.....	no	yes	BLEEDING TENDENCY.....	no	yes
ANEMIA.....	no	yes	STROKE.....	no	yes	MITRAL VALVE PROLAPSED.....	no	yes
TUBERCULOSIS.....	no	yes	HEPATITIS.....	no	yes	HIGH BLOOD PRESSURE.....	no	yes
DIABETES.....	no	yes						

REVIEW OF SYSTEM

Do you have or have had within the past year:

WEIGHT CHANGE.....	no	yes	SWOLLEN FEET/ANKLES.....	no	yes	SEIZURES.....	no	yes
DRY EYES.....	no	yes	SKIN RASH.....	no	yes	JOINT OR MUSCLE PAIN.....	no	yes
CHRONIC COUGH.....	no	yes	CHRONIC DIARRHEA.....	no	yes	SWOLLEN LYMPH NODES.....	no	yes
CHEST PAIN.....	no	yes	JAUNDICE.....	no	yes	EASY BLEEDING.....	no	yes
RAPID HEART BEAT.....	no	yes	Depression.....	no	yes	EASY BRUISING.....	no	yes

WOMEN ONLY:

Age period began_____ Number of pregnancies _____ Did you breast feed? no yes

Do you do regular breast self-examinations? no yes Breast lump or discharge? no yes

Date of last mammogram_____

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CONSULTATION QUESTIONNAIRE

So that we may answer your questions and meet your needs, we ask that you take a moment to answer the following. Your input will help Dr. Lyos and our staff to customize a surgical plan for you.

I learned about you from: _____

My cosmetic surgery goals are:

1. _____
2. _____
3. _____

My time frame for surgery is:

As soon as possible _____ Soon _____

1-3 months from now _____ 6-12 months _____

Just need information _____

Are you interested in a complimentary skin care evaluation today? YES NO

I have determined a budget for my surgery: YES NO

Estimate $_____ to $_____

Health or personal factors that may affect my surgery:

1. _____
2. _____

Comments:

_____

_____

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RESPONSIBLE PARTY AGREEMENT & FINANCIAL POLICY

_____ Initials
Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept Visa, MasterCard, Discover, and American Express credit cards.

_____ Initials
Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor-in other words, if you agree to have your insurance company pay the doctor directly.

_____ Initials
If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any over payment to you.

_____ Initials
We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit.

_____ Initials
Not all insurance plans cover all services. **In the event your insurance plan determines service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.**

_____ Initials
It is your responsibility to know if we are "in network" or "out of network" with your insurance company. If we are "out of network" with you insurance company it is you responsibility to know what your benefits are.

_____ Initials
All past due accounts must be paid before you can be seen by your doctor, unless previous payment plans have been made.

_____ Initials
I do hereby assign all payments & insurance benefits to be paid directly to Andrew T. Lyos, M.D.

_____ Initials
I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

I understand that I am financially responsible for all charges, whether or not covered in whole or in part by insurance. If these services provided by Dr. A. Lyos are covered by insurance, I authorize Dr. Lyos to release my medical records for insurance purposes and to file with my insurance carrier on my behalf.

X _____ _____

Patient Signature Date

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NOTICE OF PRIVACY PRACTICES

I have reviewed the office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this disclosure.

_____

PATIENT NAME (Please Print)

_____

SIGNATURE OF PATIENT

_____

DATE