PLASTIC SURGEONS OF NORTHERN ARIZONA

PATIENT REGISTRATION (Please Print Legibly)

PATIENT INFORMATION

Patient's Legal Name_____ _____
Last First Middle Nickname Social Security Number

Date of Birth_____ _____ Sex_____ Marital Status_____
Month Day Year Age

Patient's **Mailing Address**_____
City State Zip

Patient's **Actual Address** _____
(If Different from above) City State Zip

Home Phone_____Cell_____E-Mail_____

Employer_____Work Phone_____

Employer
Address_____
Street City State Zip

Family Physician_____**Referred by**_____

In Case of Emergency, Notify_____

INSURANCE INFORMATION (COPY OF CARD IS REQUIRED)

Primary Ins. Name_____

Group Insurance /Company Name_____

Insured Name_____**DOB**_____**Sex**_____

Secondary Insurance Name_____

Group Insurance/Company Name_____

Insured Name_____**DOB**_____**Sex**_____

RESPONSIBLE PARTY IF DIFFERENT FROM ABOVE

Name_____Home Phone_____Work Phone_____

Address_____DOB_____

SS#_____Relationship to Patient_____

Employer_____Employer Address_____

WORKMAN'S COMPENSATION INFORMATION

Date of Injury_____ Claim #_____ Insurance Carrier_____

Employer_____ Work Phone_____

Address_____

AUTHORIZATION

I hereby authorize Plastics Surgeons of Northern Arizona (PSNA) to furnish information to insurance carriers concerning this illness/accident, and hereby irrevocably assign to PSNA all payments for medical services rendered. I understand that it is my responsibility to know the benefits provided by my insurance company, and that some services may not be covered by insurance. I understand that I am financially responsible for all charges whether or not covered by insurance, and that co-payments are due and payable at the time of service.

X_____
Signature **Date**

REV: MAY/2025

PLASTIC SURGEONS of Northern Arizona | THE HAND CENTER of Northern Arizona

HEALTH HISTORY

Name: _____ Age _____

Height _____ Weight_____ BMI (body mass index, if known)_____

Have you been vaccinated for COVID-19? ___ Yes ___ No Booster? ___ Yes ___ No

SOCIAL HISTORY:
Are you currently using tobacco? ___Yes ___No If yes, what year did you start? _____
Packs per day _____ Smokeless tobacco? ____Yes ____No
Have you used tobacco in the past? ___Yes ____No **If yes,** what **year** did you start and what **year** did you quit?
Year started _____ Year quit _____

Do you vape? ___Yes ___No **If yes,** is there nicotine in the vape? ___ Yes ___ No
Are you currently using nicotine from any other source? ___ Yes ____ No

Alcohol use: ___Never ____Rare ____Moderate ____ Daily
Recreational drug use: ___Yes ____No If yes, what drug(s)? _____
Are you approved for Medical Marijuana use? ____Yes ___No

Chronic opioid user? ___Yes ___No If yes, do you have a pain contract? ___Yes ___No

Do you exercise routinely? ___Yes ___No
Can you climb a flight of stairs without getting short of breath? ___Yes ___No

MEDICATIONS/ALLERGIES:
Have you ever had an allergic reaction to any medications? ___Yes ___No If yes, what medication?
_____ and what reaction?_____

Have you ever had an allergic reaction to X-ray or Contrast Dye? ____Yes ___No If yes, describe: _____
Have you ever had a latex allergy? ___Yes ___No Have you ever had a tape/adhesive allergy? ___Yes ___No

Prescription Medications Dosage (mg) Frequency (once, twice per day, etc.)
_____ _____ _____
_____ _____ _____
_____ _____ _____
Non-Prescription Medications (including over-the-counter drugs, supplements, herbs, vitamins, aspirin, etc)
_____
Preferred Pharmacy you use:
_____
Have you taken cortisone/steroid drugs? ___Yes ___No
Have you ever had blood products transfused? ___Yes ___No If yes, when? _____ where?_____

PLEASE COMPLETE PAGE 2 OF HISTORY

PAST MEDICAL HISTORY: Please check illnesses / conditions that you have had or currently have:

Asthma	Bleeding tendencies	Blood clots	Bronchitis	Cancer (type)	Diabetes	Elevated cholesterol
Heart disease	Hepatitis	High blood pressure	HIV	Sleep apnea	Glaucoma	Kidney disorder/ stones
Jaundice	Obesity	Pneumonia	STD	Nervous disorder	Stroke/TIA	Tuberculosis
Reflux/PUD	Rheumatic fever	Cold sores/ fever blisters	Hives/rash	Eczema	Frequent urination	Burning/painful urination
Blood in urine	Skin diseases	Thyroid disorder	Dizziness/loss of consciousness	Easy bruising	Heavy bleeding after surgery	Slow to heal after cuts
Multiple Sclerosis	Fragile skin/burn easily	Other				

Are you currently experiencing any cold or flu-like symptoms? _____ yes ____ no

SURGICAL HISTORY: Previous operations or hospitalizations.
Please list procedure, year, and describe anesthesia complications (if any):
_____
_____
_____
_____

Have you had any serious injuries, broken bones, etc? Yes___ No___ If yes, please list
_____
_____

FAMILY HISTORY:

Please check illnesses that have occurred in any of your **BLOOD RELATIVES,** and list which relative(s):

(M = mother. F = father. B = brother. S = sister. PGM = paternal grandmother. MGM = maternal grandmother PGF = paternal grandfather. MGF = maternal grandfather. A = aunt. U = uncle. C = cousin. CH = child. GC = grandchild)

Bleeding tendencies _____ Diabetes _____ High Blood Pressure _____
Nervous disorder _____ Cancer (type)_____
Heart disease _____ Kidney disease _____ Stroke _____
Other illness: _____

Woman Only:
Are you pregnant? ___Yes ___No
During pregnancy do you have hypopigmentation or masking? ___Yes ___No
Do you have regular periods? ___Yes ___No
Are you going through menopause? ___Yes ___No
Date of last menstrual period: _____
Date of most recent mammogram: _____

Patient or responsible party signature _____ Date: _____

PLASTIC SURGEONS
of Northern Arizona

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Plastic Surgeons of Northern Arizona (PSNA) is dedicated to maintaining the privacy of your personal health information. Each time a patient visits this office a record is made that describes the treatments and services provided. Federal law outlines specific privacy protections and individual rights related to the information we maintain that identifies you as a patient. Protected information includes demographic data and facts about your past, present, or future physical or mental health. Our office has put in place policies and procedures to help protect your health information. We are required to provide this notice outlining our legal duties and responsibilities related to the use and disclosure of patient identifiable health information, privacy practices, and examples of how your information may be used or disclosed.

PSNA will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a permanent location. You can request a copy of our most current notice at any time. Revisions of the notice will be effective for all healthcare information this office maintains: past, present, or future.

According to federal law, PSNA may use your individually identifiable information for the following purposes without your authorization:

1. Treatment: We may use and disclose your identifiable information to treat you and assist others in your treatment. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition, or we may disclose information to others who take part in your care, such as your spouse, children, or parents.
2. Payment: We may use your health information to bill and collect payment for services provided. This may include providing your insurance company with the details of your treatment, sharing your payment information with other treatment providers, contacting you over the phone or through email about balances, or sending unpaid balances to a collection agency.
3. Healthcare operations: We may use and disclose health information to operate our business. For example, your health information may be used to evaluate the quality of care we provide, for state licensing, or to identity you by name when you visit our facility.
4. Appointment reminders: We may use and disclose your information to remind you of appointments. We may also correspond with you by mail or telephone for other purposes.
5. Treatment options: We may use your health information to inform you of treatment options or other health-related services which may be of interest to you.
6. Business associates: We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office, such as our answering service, billing company, and transcription services. Our business associates agree to protect the privacy of your information.

PSNA may disclose your health information without your authorization when permitted or required by law, including:

- For public health activities including reporting of certain communicable diseases.
- For worker's compensation or similar programs as required by law.
- To authorize when we suspect abuse, neglect, or domestic violence.
- To health oversight agencies.
- For certain judicial and administrative proceedings pursuant to an administrative order.
- For law enforcement purposes.
- For research purposes under strictly limited circumstances.
- To avert a serious threat to your health and safety or that of others.
- For government purposes such as military service or for national security.
- In the event of an emergency or for disaster relief.
- In any other instance required by law.

PSNA may also disclose your information to family members and/or other persons involved in your care or payment for your care. We may leave messages for you at home or work about your visits or test results. If you do not want us to do so, please inform our staff or our privacy officer in writing or by calling.

PSNA NOTICE OF PRIVACY CONTINUED

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that we have already acted on it. Should you require your records to be released, PSNA will provide you with an authorization form to complete and return to the address listed on it.

YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF PSNA. THE INFORMATION CONTAINED IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

1. Restrictions on use and disclosure: You have the right to request restrictions on how we use and disclose your health information. This includes requests to restrict disclosure of your health information to only certain individuals, or entities, involved in your care such as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.
2. Confidential communications: You have the right to request that we communicate with you in a particular manner or at a certain location. For example, you may request that we only contact you at home. We will accommodate reasonable requests.
3. Access: You have the right to inspect or request a copy of records used to make decisions about your health care, including our medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under exceptional circumstances, we may deny your request to inspect and/or copy your records. You may request a review of most types of denials.
4. Record amendment: You have the right to request amendments to your health records created by and for PSNA if you feel that they are incorrect or incomplete. We may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement or rebuttal statement.
5. Accounting of disclosures: You have the right to receive an accounting of the disclosures. This means you may request a list of certain disclosures PSNA has made of your records. Upon request, we will provide this information to you one (1) time free during each twelve (12) month period. There may be a fee for additional copies.
6. Copy of notice: You have the right to request that we provide you with a paper copy of this Notice of Privacy Practices.

If you have any questions about this notice, please contact the PSNA privacy officer at 1020 North San Francisco Street, Suite 200, Flagstaff, AZ, 86001 or call (928)774-2300 ext 111, or toll free 800-962-1390 ext 111. If you feel your privacy right have been violated, you have the right to file a written complaint with our office. You may also file a complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy. I have had the opportunity to review and/or receive a copy of PSNA's Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, and protected.

_____ _____

Printed Patient Name Name/Relationship if signed by other than patient

_____ _____

Patient Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of this Notice of Privacy Practices but could not because:

___ Individual declined to sign ____ Communication Barrier

___ Other: _____

Effective date of notice: January 16, 2019

PLASTIC SURGEONS OF NORTHERN ARIZONA

PATIENT RIGHTS AND RESPONSIBILITIES

YOU HAVE THE RIGHT TO:

1. Be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care needs.
2. Participate in decisions involving your health care, except when such participation is contraindicated for medical reasons.
3. Refuse or withdraw consent for treatment or give conditional consent for treatment.
4. Have medical and financial records kept in confidence and be assured that the release of such records shall be by written consent of the patient or the patient's legal representative, except as otherwise required or permitted by law.
5. Be informed of the following:
    a. Proposed surgical procedures and the risks involved and information concerning your diagnosis, evaluation, treatment and prognosis;
    b. Policy on advance directives as required by state or federal law and regulations;
    c. Policy on patient privacy;
    d. Costs of services prior to obtaining services or prior to a change in charges for services / payment policies;
    e. Notice of third-party coverage;
    f. The patient grievance process or the process of expressing suggestions;
    g. After hours and emergency care;
    h. Information regarding physician and facility credentialing, ie: proof of certification, liability coverage etc.

YOU HAVE A RESPONSIBILITY TO:

1. Be honest about everything that relates to you as a patient.
2. Cooperate with your doctor by following directions and asking questions when you do not understand information or instructions.
3. Inform your doctor of any care or medications you are receiving from other doctors.
4. Accept responsibility for your actions when you do not follow directions or refuse treatment.
5. Comply with all financial policies.
6. Keep us informed of changes in your address, phone number and insurance coverage and provide a copy of your current insurance card and provide a copy of your current insurance card.
7. Provide valid and current photographic identification.

It is the goal of Plastic Surgeons of Northern Arizona to provide excellent care and fully satisfy the needs of our patients. Please let us know if you have any suggestions, concerns or complaints by contacting our Administrator at 928-214-2111 or 800-962-1390 ext 111.