Parker Plastic Surgery
James A. Parker, M.D.
1181 Langford Drive, Bldg 300-105
Watkinsville, GA 30677
P: 706.543.0404 | F: 706.549.0065

Patient Information

First Name:_____ MI:_____ Last:_____

Preferred Name:_____ Prev Last Name:_____ Female Male Nonbinary

DOB:_____ Age: _____ Preferred Pronouns:_____

How did you hear about Dr. Parker? ☐ Google ☐ Facebook ☐ Other:_____

☐ Patient Referral: _____ ☐ Friend/Family:_____ ☐ Dr. Referral:_____

Home Address:_____ Apt. _____

City:_____ State:_____ Zip:_____

Home Ph:_____ Cell Ph:_____ Cell Carrier:_____

Email address:_____

Employer:_____ Address:_____

Occupation:_____ Work Phone:_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Responsible Party *(if patient is under 18 years old)*

Relationship:_____

Last Name:_____ First Name:_____ MI:_____

Address:_____ Apt. #_____

City:_____ State:_____ Zip:_____

Home Ph:_____ Work Ph:_____ Cell Ph:_____

Emergency Contact

Relationship:_____

Last Name:_____ First Name:_____ MI:_____

Address:_____ Apt. #_____

City:_____ State:_____ Zip:_____

Home Ph:_____ Work Ph:_____ Cell Ph:_____

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Insurance Information

Primary Ins. Co:_____

Ins. Address:_____

Insured's Name:_____

Insured's DOB:_____ Insured's SSN:_____

Policy:_____ Group:_____

Secondary Ins. Co:_____

Ins. Address:_____

Insured's Name:_____

Insured's DOB:_____ Insured's SSN:_____

Policy:_____ Group:_____

Assignment and Release

I have insurance coverage and assign all medical benefits, if any, otherwise payable to me for services rendered. I understand that it is my responsibility to verify that Dr. Parker is a participating provider with my insurance plan and that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Parker to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured/Guardian Date

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1181 Langford Drive | Watkinsville, GA 30677
706.543.0404
www.parkerplasticsurgery.com

Please fill out form completely – Do not leave any spaces blank – If it does not apply, please write in "N/A"

Name _____ Date _____

Date of Birth _____/_____/_____ Height _____ Weight _____ Age _____

Primary Care Physician _____

Reason for today's visit _____

Allergies (Any meds you cannot take?)_____

Date of injury/first symptom _____/_____/_____ Is condition/injury work related? Yes_____ No_____

Do you have a hospital preference? (circle one) Athens Regional ◯ St. Mary's ◯ No Preference ◯

List previous surgeries and dates if known _____

_____

_____

Have you or any family member ever had complications related to anesthesia including high fever?_____

List all current medications (include aspirin, birth control, vitamins)_____

_____

_____

Past Medical History: Have you ever had the following…

	YES	NO		YES	NO		YES	NO
Anemia	☐	☐	Heart murmur	☐	☐	Poor circulation/blood clots	☐	☐
Cancer	☐	☐	Irregular heart beat	☐	☐	Seizure	☐	☐
If Yes, type _____			Thyroid problems	☐	☐	Bowel/stomach disorders	☐	☐
Diabetes	☐	☐	Hepatitis	☐	☐	Emphysema/COPD	☐	☐
High blood pressure	☐	☐	Keloids/excessive scarring	☐	☐	HIV/Immunocompromised	☐	☐
Kidney disease	☐	☐	Rheumatic fever	☐	☐	Cough > 3 wks	☐	☐
Stroke	☐	☐	Ulcers	☐	☐	Sleep apnea/CPAP use	☐	☐
Asthma	☐	☐	Arthritis	☐	☐	Jaundice	☐	☐
Heart disease	☐	☐	Excessive bleeding	☐	☐	Other _____		

Family History: Has any blood relative had the following… ☐ Adopted or unknown

	YES	NO		YES	NO		YES	NO
High blood pressure	☐	☐	Heart disease	☐	☐	Kidney disease	☐	☐
Melanoma	☐	☐	Cancer	☐	☐	Blood clots	☐	☐
Diabetes	☐	☐	If Yes, type _____			Stroke	☐	☐

Reviews of Systems: Do you have or have you had in the last year…

	YES	NO		YES	NO		YES	NO
Weight change	☐	☐	Swollen ankles/feet	☐	☐	Seizures	☐	☐
Dry eyes	☐	☐	Skin rash	☐	☐	Joint or muscle problems	☐	☐
Chronic cough	☐	☐	Chronic diarrhea	☐	☐	swollen lymph nodes	☐	☐
Chest pain	☐	☐	Jaundice	☐	☐	Easy bleeding	☐	☐
Rapid heart beat	☐	☐	Depression	☐	☐	Easy bruising	☐	☐
Sinus problems	☐	☐	Urinary problems	☐	☐	Other _____		

Do you smoke/use tobacco products? ☐ Yes ☐ No Packs/Day _____ Other _____

Do you drink alcohol? ☐ Yes ☐ No Drinks/Day _____

Is there any chance that you are pregnant? ☐ Yes ☐ No

I verify that the above information is true and accurate to the best of my knowledge.

X _____ _____

Signature of Patient/Responsible Party Date

Parker
PLASTIC SURGERY

HIPAA Information and Consent Form

Patient Name: DOB:

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the
patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

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PLASTIC SURGERY

Consent to Communicate

Patient Name:

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email			☐	----------
☐ Email Appointment Reminders				
☐ Email Medical Information				
☐ Email Office Specials				
☐ Send Regular Mail			☐	----------
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Message - if ok, please list cell carrier (e.g., AT&T):			☐	----------
☐ Text Appointment Reminders				
☐ Text Office Specials				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

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Patient Name:_____ **Date:**_____

Our goal is to respond to all your needs and concerns as a patient, and it is our pleasure to provide a wide range of cosmetic services in addition to our reconstructive procedures. If you are interested in or have ever thought about having a cosmetic procedure, please take a few moments to fill out this optional questionnaire.

What are your areas of concern? (Please check all that apply).

☐ Breasts too small	☐ Facial Lines/Wrinkles	☐ Arms
☐ Breasts too large	☐ Drooping Eyes	☐ Botox
☐ Sagging Breasts	☐ Puffy Eyes	☐ Facial Fillers
☐ Abdominal Area	☐ Neck	☐ _____
☐ Hip/Thigh Area	☐ Thin Lips	☐ _____

Please indicate your interest level.

☐ Very interested! I'm ready to get started.
☐ Somewhat interested. I have some questions and want to know more.
☐ I'm interested in financing.
☐ Not that interested, but thank you.

Additional Comments:_____

_____

_____