



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



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	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation/blood clots	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Seizure	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, type _____			Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Bowel/stomach disorders	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Keloids/excessive scarring	<input type="checkbox"/>	<input type="checkbox"/>	HIV/Immunocompromised	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Cough > 3 wks	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Sleep apnea/CPAP use	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Excessive bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

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

	YES	NO		YES	NO		YES	NO
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, type _____			Stroke	<input type="checkbox"/>	<input type="checkbox"/>

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

	YES	NO		YES	NO		YES	NO
Weight change	<input type="checkbox"/>	<input type="checkbox"/>	Swollen ankles/feet	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>	Joint or muscle problems	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Chronic diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	swollen lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Rapid heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Urinary problems	<input type="checkbox"/>	<input type="checkbox"/>	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



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: _____



Consent to Communicate

Patient Name:

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

METHOD	YES	NO
CALL PHONE		
LEAVE VOICEMAIL		
SEND EMAILS		
SEND MAIL		
SEND TEXTS		

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

Name	DOB	Relationship	Release Results	Comments
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> 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
- Breasts too large
- Sagging Breasts
- Abdominal Area
- Hip/Thigh Area
- Facial Lines/Wrinkles
- Drooping Eyes
- Puffy Eyes
- Neck
- Thin Lips
- Arms
- Botox
- Facial Fillers
- _____
- _____

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: _____

