PH (913) 492-3443

JOHN MICHAEL QUINN, MD, FACS

FAX (913) 492-1881

QUINN PLASTIC SURGERY CENTER

6920 W. 121st ST. OVERLAND PARK, KS 66209

***PLEASE PRINT CLEARLY***

## PATIENT INFORMATION

LAST NAME | FIRST NAME | M.I. | NICKNAME

ADDRESS | APT # | CITY | STATE | ZIP COE

HOME PHONE | CELL PHONE | WORK PHONE

I GIVE QUINN PLASTIC SURGERY PERMISSION TO LEAVE A DETAILED VOICEMAIL AT THIS NUMBER: ☐ CELL ☐ HOME ☐ WORK

DATE OF BIRTH | OCCUPATION | GENDER ☐ F ☐ M

EMAIL ADDRESS *Please print clearly*

RACE: *(CHECK ALL THAT APPLY)*

☐ Black/African American
☐ White
☐ American Indian/Alaskan Native
☐ Hispanic
☐ Other
☐ Asian
☐ Native Hawaiian/Pacific Islander
☐ Prefer not to disclose

ETHNICITY: ☐ Hispanic ☐ Not Hispanic ☐ Prefer not to disclose

PREFERRED PHARMACY | PHARMACY ADDRESS | PHARMACY PHONE

REASON FOR TODAY'S VISIT:

## INSURANCE INFORMATION

(SKIP IF THIS VISIT IS COSMETIC)

PRIMARY INSURANCE | SECONDARY INSURANCE | I AM THE: ☐ PATIENT ☐ GUARANTOR

GUARANTOR LAST NAME | FIRST NAME | M.I.

ADDRESS | APT # | CITY | STATE | ZIP CODE

DATE OF BIRTH | SOCIAL SECURITY NUMBER | GENDER ☐ F ☐ M

**PLEASE PRESENT YOUR INSURANCE CARD (IF APPLICABLE) AND PHOTO ID FOR SCANNING* (italic)

PLEASE TELL US WHO REFERRED YOU SO THAT WE MAY THANK THEM: | REFERRAL PHONE

I GIVE QUINN PLASTIC SURGERY PERMISSION TO DISCUSS MY MEDICAL CARE WITH: 1) 2)

**PATIENT/GUARANTOR SIGNATURE** **DATE**

## HISTORY & PHYSICAL EXAMINATION
(Confidential Record )

**Last Name** **First** **Middle**

**Age** ________ **Sex** M____ F____

**Referred to Dr. Quinn By:** ______________________________

**REASON FOR VISIT** (Details Please) ______________________________

**PREVIOUS SURGERIES:**
______________________________
______________________________
______________________________

**HOSPITALIZATIONS/MEDICAL PROBLEMS/ SERIOUS ILLNESS/INJURY:**
ASTHMA DIABETES
HIGH BLOOD PRESSURE HEART DISEASE
**OTHER:**______________________________
______________________________

**LIST CURRENT MEDICATIONS, VITAMINS & SUPPLIMENTS:**
______________________________
______________________________

**LIST DRUG ALLERGIES:**
______________________________

**SOCIAL HISTORY:**
Marital Status: S M W DIV SEP
Are You Pregnant? Yes / No
Smoke? How Much? ________ Yes / No
Bleeding Problems? Yes / No
Taken Accutane? Yes / No
Drink Alcohol Daily? Yes / No
Take IV Drugs? Yes / No
Have AIDS risk or HIV Positive? Yes / No
Taking Aspirin? Yes / No
History of Blood Clots/DVTs? Yes / No

**Patient has been instructed to DISCONTINUE fish oil, ASA, aspirin-like products, Vit. E, & Diet Pills.**

**FAMILY HISTORY:** Have any relatives had the following? If so, whom?

| | | |
|---|---|---|
| **Diabetes** | Yes / No | ________ |
| **High Blood Pressure** | Yes / No | ________ |
| **Heart Condition** | Yes / No | ________ |
| **Arthritis** | Yes / No | ________ |
| **Breast Cancer** | Yes / No | ________ |
| **Seizures** | Yes / No | ________ |
| **Melanoma** | Yes / No | ________ |
| **Blood Clots/DVT** | Yes / No | ________ |

**HEALTH TODAY:**

| | | |
|---|---|---|
| Shortness of Breath | Yes / No | ________ |
| Chest Pain | Yes / No | ________ |
| Fevers | Yes / No | ________ |
| Headaches | Yes / No | ________ |
| Weight Loss | Yes / No | ________ |

**Height** ________ **Weight** ________

**To be completed by Dr. John M. Quinn, MD.**

**HEENT:** **PERRLA ORIS WNL.**
**NECK:** **SUPPLE**
**CHEST:** **RRR CLEAR**
**BREASTS:**
**ABDOMEN:** **SOFT NO MASSES**
**EXT:** **PULSES 2+ / 4+**

**IMPRESSION:**

## Financial Policy and Consent for Treatment

As a service to our patients, we will file your insurance claims when appropriate.* Unfortunately, not all services are paid by insurance. Ultimately, the person authorizing treatment (guarantor) is responsible for payment of the services provided. It is your responsibility to know your insurance benefits.

Your insurance may not cover your charges for reasons including, but not limited to the following:

- your insurance policy does not cover this service
- your visit/treatment is cosmetic in nature
- your insurance is not in effect
- you did not obtain a referral for this care (if required)
- we are not contracted with your insurance company

If your visit/treatment is to be submitted to your insurance, you must provide verification of coverage at the time of service. If you do not have the necessary billing information, charges will be due in full at the time of service.

***Cosmetic visits/treatment are not filed with insurance. If you are unsure whether your visit is cosmetic, please ask when you check in.***

Appointments that are not canceled at least one hour prior to the appointment time will be considered a no-show. Our office does not charge for missed appointments, however three no-show appointments in a six-month period may result in discharge from the practice.

✓ I consent to diagnostic procedures and medical care as deemed necessary for my care.
✓ I acknowledge receipt of the HIPAA Notice of Privacy Practices and my questions, if any, have been answered.
✓ I acknowledge that I have read and agreed to the financial policy. A copy of this signature is as valid as the original.

Patient Name (please print) ______________________________

Patient/Guarantor Signature ______________________________ Date ____________

Guarantor Name (please print) ______________________________

❑ **INSURANCE PATIENTS (please check if applicable, and initial)**
✓ I authorize Quinn Plastic Surgery to file a claim to my insurance company on my behalf.
✓ I authorize Quinn Plastic Surgery to release medical information necessary to file a claim.
✓ I irrevocably authorize my insurance carrier to assign benefits to Quinn Plastic Surgery.
✓ I understand that I am financially responsible for all charges not covered by my insurance carrier. INITIAL: __________

❑ **MEDICARE PATIENTS (please check if applicable, and initial)**
✓ I request that payment be authorized, and irrevocably authorize Medicare to pay benefits directly to Quinn Plastic Surgery.
✓ I authorize any holder of medical information to release to the SSA and its agents any information needed to determine benefits payable.

INITIAL: __________