The LETT CENTER
Aesthetic & Reconstructive Surgery
& Medi-Spa

# *Personal Information*

Primary Care Provider _____
Referring Provider _____
Appointment Date _____

Patient Last Name _____ First Name _____ MI _____
Address _____
City, State, Zip Code _____

Home Phone _____ Cell _____
Work Phone _____ Ext _____
Date of Birth (mm/dd/yyyy) _____ Gender _____ Marital Status _____
Social Security _____

Patient Employer _____
Employer's Address _____

Spouse/Significant Other Information
Name _____ Date of Birth _____
Phone Number _____ Cell Phone _____
Employer _____
Employer's Address _____

Do you have an Advanced Will Directive or Living Will? YES NO
Please ask the receptionist if you are unsure~ If you circled YES, please bring a copy for our records.

Are you currently living at any of the listed facilities? If YES, please choose one.
_____ Skilled Nursing _____ Hospice _____ Rehab Facility _____ Other
Facility/Alternate Address _____ Phone _____

Patient E-Mail _____

RACE _____ American Indian or Alaska Native _____ Asian _____ White
_____ Black or African American _____ Native Hawaiian or Other Pacific Islander
Ethnicity _____ Hispanic or Latino _____ Not Hispanic or Latino

Preferred Language _____ Interpreter Needed: YES NO

Emergency Contact person **(OTHER than listed above)**
Name _____ Relationship _____
Phone Number _____ Cell Phone _____

**Billing Policy**

The Surgical Clinic, PLLC will file your insurance and collect self pay accounts. You, the patient will be responsible for any personal balances. Any account turned to an outside collection agency will accrue additional fees on the unpaid balance including any attorney/court costs in collecting that balance.

Signature _____ Date _____

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**Patient**_____ **Date:**_____

**Patient Questionnaire: Coronavirus Information**

1. Have you been out of the country in the past 30 days?

2. Have you been in contact with anyone under investigation or treatment with a confirmed case of the coronavirus?

3. Do you currently have any signs & symptoms of a cold, cough, or lower respiratory illness? (shortness of breath, etc.)

**IMPORTANT:** Please be advised that only 1 additional family member &/or caregiver per patient will be allowed to accompany each patient. Please notify all patients for these issues.

PATIENT SIGNATURE:_____

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**MEDICAL & AESTHETIC QUESTIONNAIRE:**

**DATE: _____ DOB:_____**

**NAME:_____**

HOW DID YOU HEAR ABOUT US?_____

WHAT ARE YOU BEING SEEN FOR TODAY AT THE LETT CENTER?_____

| |
|---|
| WHEN DID YOUR SYMPTOMS BEGIN? |
| WHERE DO SYMPTOMS OCCUR ON YOUR BODY? |
| DESCRIBE SYMPTOMS |
| PAIN ON A SCALE OF 1 (LEAST) TO 10 (WORST) |
| WHAT SITUATION CAUSES SYMPTOMS? |
| HOW LONG DO SYMPTOMS LAST? |

HAVE YOU BEEN TREATED FOR THIS PROBLEM IN THE PAST? YES___ NO___ IF YES, WHEN?_____

DO YOU HAVE AN INTEREST IN ANY OF OUR AESTHETIC SERVICES? YES___ NO___ IF YES, WHAT?_____

HAVE YOU EVER SEEN A DOCTOR FOR YOUR SKIN? YES___ NO___ IF YES, PLEASE EXPLAIN_____

- o I TAKE NO MEDICATIONS OR LIST MEDICATIONS BELOW INCLUDING OVER THE COUNTER VITAMINS, SUPPLEMENTS, PRESCRIPTION DOSAGES, AND ANY TOPICAL MEDICATIONS

| | |
|---|---|
| | |
| | |
| | |
| | |

- o I HAVE NO ALLERGIES TO MEDICINES, OR LIST ALL ALLERGIES AND REACTIONS BELOW.

| | |
|---|---|
| | |
| | |
| | |

HAVE YOU EVER USED ANY OF THE FOLLOWING MEDICATIONS? YES___ NO ___ CHECK THOSE THAT APPLY

- o HYDROQUINONE
- o ACYCLOVIR
- o RENOVA
- o VALTREX
- o TRETINOIN/RETIN-A
- o ACCUTANE

ARE YOU PREGNANT? YES ____ NO____ ARE YOU TRYING TO GET PREGNANT? YES ____ NO ___.

ARE YOU LACTATING? YES____NO_____ NUMBER OF PREGNANCIES _____

DID YOUR SKIN DARKEN/MASK WITH PREGNANCY? YES____ NO_____

- o I HAVE HAD NO SURGERIES, OR LIST ALL SURGERIES INLCUDING COSMETIC/AESTHETIC SURGERIES BELOW

| DATE | TYPE OF SURGERY | LOCATION/HOSPITAL | COMPLICATIONS? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

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**MARITAL STATUS:**____ MARRIED____DIVORCED____SINGLE____WIDOWED____SEPARATED____
WHO LIVES WITH YOU?_____

**TOBACCO USE (INCLUDING SNUFF, CIGARS, CHEWING TOBACCO, CIGARETTES, VAPOR, ETC):**
YES___NEVER____ NOT NOW____IF YES, FREQUENCY & WHAT TYPE?_____

**DRUG USE:** YES___NEVER____NOT NOW____ IF YES, FREQUENCY & WHAT TYPE?_____

**ALCOHOL USE:** YES___NEVER___NOT NOW____ IF YES, HOW MUCH & HOW OFTEN?_____

**THIS QUESTIONNAIRE IS FOR THE PAST 6 MONTHS ONLY, PLEASE CIRCLE IF IT APPLIES TO YOU.**

| | | | |
|---|---|---|---|
| **GENRAL/ CONSTITUTIONAL** | **GASTROINTESTINAL** | TROUBLE WALKING | DEPRESSION |
| GENERAL GOOD HEALTH | NAUSEA VOMITING | **RESPIRATORY** | FREQUENT HEADACHES |
| RECENT WEIGHT CHANGE | ABDOMINAL PAIN | SHORTNESS OF BREATH | PARALYSIS |
| NIGHT SWEATS, FEVERS | BOWEL PROBLEMS | COUGH | **BREAST** |
| FATIGUE | RECTAL BLEEDING | WHEEZING/ASTHMA | BREAST LUMP |
| MRSA | **ENT** | COUGHING UP BLOOD | BREAST PAIN |
| **CARDIOVASCULAR** | HEARING LOSS | **OPTHALMOLOGIC** | BREAST DISCHARGE |
| CHEST PAIN | EAR RINGING | WEAR GLASSES | **GENITOURINARY** |
| PALPITATIONS | SINUS PROBLEM | WEAR CONTACTS | BLOOD IN URINE |
| HEART PROBLEMS | NOSE BLEEDS | DOUBLE VISION | KIDNEY STONES |
| SWELLING HANDS/FEET | SORE THROAT | BLURRED VISION | **SEXUAL PROBLEMS** |
| **ENDOCRINE** | **MUSCULOSKELETAL** | EYE DISEASE/INJURY | **WOMEN ONLY** |
| EXCESSIVE THIRST | MUSCLE PAIN/CRAMPS | CHANGE IN HAIR/NAILS | MENSTRUAL PROBLEM |
| FREQUENT URINATION | STIFFNESS/SWELLING | RASH/ITCHING | DATE OF LAST PERIOD: |
| THYROID DISEASE | JOINTS | GLAUCOMA | |
| HORMONE PROBLEMS | JOINT PAIN | **NEUROLOGIC** | **MEN ONLY** |
| EASILY BRUISED | | INSOMNIA | TESTICLE PAIN |
| | | CONFUSION | |

**PAST MEDICAL HISTORY:** CIRCLE ALL THAT APPLY

| | | | |
|---|---|---|---|
| DIABETES | HEPATITIS | STROKE | FAINTING/DIZZINESS |
| MIGRAINES/HEADACHES | | SEIZURES | BLOOD CLOTS |
| HEART DISEASE | HIGH BLOOD PRESSURE | SUBSTANCE ABUSE | CANCER (BREAST) |

HAVE YOU EVER HAD A MAMMOGRAM? YES___ NO___
IF SO, WHEN WAS YOUR LAST ONE?_____
WHAT'S YOUR WEIGHT?_____ HEIGHT?_____

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**FAMILY HISTORY:** CIRCLE ALL THAT APPLY

| | | | | |
|---|---|---|---|---|
| DIABETES | HEPATITIS | STROKE | FAINTING/DIZZINESS | |
| MIGRAINES/HEADACHES | | SEIZURES | BLOOD CLOTS | |
| HEART DISEASE | HIGH BLOOD PRESSURE | | SUBSTANCE ABUSE | CANCER |

WHAT TYPE OF CANCER? AND WHOM?_____
PARENTS STILL LIVING? YES___ NO____

**ADDITIONAL AREAS OF CONCERN FOR ME:** CIRCLE ALL THAT APPLY

| | | | |
|---|---|---|---|
| FINE LINES | WRINKLES | ROUGH TEXTURE OF SKIN | TIRED LOOKING SKIN |
| SAGGING SKIN | HAIR ON FACE | UNEVEN SKIN TONE | ACNE |
| FRECKLES | DRYNESS | BREAST SIZE | UNWANTED HAIR |
| DARK CIRCLE UNDER EYES | | MAJOR LINES AROUND NOSE & MOUTH | |

DO YOU TAN EASILY? YES___NO ____
DO YOU BURN EASILY DUE TO SUN/UV EXPOSURE? YES___ NO____
HAVE YOU OR DO YOU USE A TANNING BED? YES___ NO ____
DO YOU CURRENTLY SUN BATHE? YES____ NO____
DO YOU WEAR SUNSCREEN? YES___NO____
DO YOU CHECK YOUR SKIN MONTHLY FOR ABNORMALITIES? ____YES ____NO
DO YOU HAVE A HISTORY OF KELOIDS OR HYPERTROPHIC SCARRING?____YES____NO
HAVE YOU EVER BEEN TREATED WITH PHENOL OR TRICHLORACETIC ACID (TCA)? YES____ NO____ IF YES, WHEN?_____
HAVE YOU EVER HAD ANY LASER TREATMENTS? YES___ NO___ IF YES, WHAT TYPE & WHEN?_____
HAVE YOU EVER HAD ANY BOTOX OR DERMAL FILLER INJECTIONS?____YES ____NO, IF SO, PLEASE EXPLAIN WHICH ONES:_____
WHEN WAS YOUR LAST INJECTION?_____
DO YOU EASILY BRUISE WITH INJECTIONS?____YES____NO
DO YOU HAVE ANY COSMETIC IMPLANTS?____YES____NO, IF SO, WHAT TYPE?_____
WHAT TYPE OF SKINCARE DO YOU CURRENTLY USE?_____

DO YOU HAVE ANY OTHER CONCERNS? YES____ NO____ IF YES, PLEASE EXPLAIN:

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## Patient Authorization

*Please use blue or black ink to fill out this form and sign below.*

Patient Name: Patient Birthdate:

*Because of the changes made by Congress, we are required to get your explicit permission regarding how your medical information is handled. You may request a copy of the Notice of Privacy Practices from our staff. Please read each authorization carefully and indicate your approval by initialing on the line provided.*

- I authorize the release of all medical records maintained by The Surgical Clinic, PLLC, which relates to services I have received from, or the results of tests ordered by The Surgical Clinic, PLLC. These records may be released as needed for my care for the processing of insurance claims, to satisfy the requirements of a managed care organization of which I am a member, and/or to my attorney regarding pending or anticipated litigation under a worker's compensation, motor vehicle accident, and/or third party liability claim.
- I am giving permission for The Surgical Clinic and its sub-specialties (listed below) to obtain my prior films, scans, labs, and any records including demographic, pharmacy and medication history that may identify me and that relates to my past, present, and/or future physical or mental health or condition and related health care services. I understand that it is my responsibility to obtain previous studies, if asked to do so. If it is necessary for an employee of The Surgical Clinic to obtain my prior films, labs, and/or other records, I am giving my permission to call and/or fax on my behalf in order to get needed medical records and films.
- I authorize direct payment of benefits from my insurance plan to The Surgical Clinic, PLLC. I understand that I am responsible for payment of professional fees charged by The Surgical Clinic, PLLC, which are not covered or not properly reimbursed under the terms of my insurance plan.

> The Surgical Clinic, PLLC, will file your insurance or collect self-pay accounts. You, the patient, will be responsible for any personal balance. Any account turned to an outside collection agency will accrue additional fees on the unpaid balance including any attorney/court costs in collecting that balance.

- I will provide The Surgical Clinic, PLLC, with the phone numbers I authorize to be used to contact me. I authorize the use of any messaging person or system, voice mail and/or answering machine to convey information regarding my care. Contact via e-mail is authorized, if I provided my e-mail address to The Surgical Clinic.
- I authorize the use of fax or e-mail to send my information to myself or other parties that have a right to receive my information. I understand that every effort is made to protect my privacy, however, no absolute privacy guarantee is given when faxes or e-mails are used.
- I understand that it is my right to request limited access to my records and to withdraw permission for the release of my records. I understand that this request must be in writing and that limiting or withdrawing my permission may result in The Surgical Clinic, PLLC, discontinuing its relationship with me. In that case, I will need to seek care from another source.

Signature:_____ Date:_____

I have been offered a copy of The Surgical Clinic's Notice of Privacy Practices for my own records. Initials:_____

My signature above also gives my permission and consent for any and all medical information maintained in or generated by The Surgical Clinic on my behalf to be released and/or discussed with the following person(s):

| Patient's family member's name | Relationship | Patient's family member's name | Relationship |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

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**Medication Record Form**
Include all over- the- counter medicine and vitamins that you take.

Patient Name: Date of Birth:

Medication and Food Allergies:

| NAME OF MEDICATION | DOSE | FREQUENCY | SPECIAL INSTRUCTIONS | DATE STARTED | DATE STOPPED | PRESCRIBED BY |
|---|---|---|---|---|---|---|
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Help avoid medication problems by using this chart to keep an updated list of your medications. Remember to take list to your doctor, pharmacist or hospital visits and keep an updated record of all prescriptions, vitamins, herbals, dietary supplements and over-the-counter medications that you are taking.

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# Our Financial Policy

E. Dwayne Lett, MD
Erica Long, PA
Kathleen Miller, FNP

_____ 1. Initial — I understand that I am required to pay for all charges on the date of services are rendered unless I am covered by a Medicare health plan in which the Physician is a participating provider, and I am being seen for services I know to be covered by my policy.

_____ 2. Initial — I understand that The Surgical Clinic Surgeons accept MasterCard/Visa/American Express, a personal check, money order or cash. If the Bank returns my check "unpayable", I will be charged a $25.00 service fee which will be due and payable within 3 days along with the amount of the original check.

_____ 3. Initial — I understand that if I receive a statement in the mail, the amount stating "my responsibility" is due in 10 days.

_____ 4. Initial — If my account exceeds 60 days, I understand that I am in collection status, and a finance charge equal to 11/2% per month may be added.

# Medical Insurance Policy

_____ 1. Initial — I understand that I am ultimately responsible for my account in full even though I have medical insurance. Should there be a problem with my insurance company not paying in a timely manner, or for the correct amount, I agree to pay the doctor and settle my differences with my insurance company.

_____ 2. Initial — I will pay all co-pays, deductibles or percentage due by the date of services.

_____ 3. Initial — I herby authorize payment to the physicians or The Surgical Clinic. I understand I am financially responsible for all charges not covered by this authorization. I also authorize that a photographic copy of this is valid as the original.

_____ 4. Initial — If my account exceeds 60 days, I understand that my account may be in a collection status.

Patient Name: _____

Patient Signature: _____ Date: _____

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# PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date:_____ Account #:_____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be effective as the original. **MY SIGNATURE WILL ALSO SERVICE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE OR CONSENT FOR DATA TO BE EXCHANGED ELECTRONICALLY BETWEEN PROVIDERS/HOSPITALS**

_____ _____
Please ***PRINT*** your name Please ***SIGN*** your name

_____ _____
Legal Representative Description of Authority

Your comments regarding Acknowledgement or Consents _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:
_____ First Name Only _____ Proper Surname _____ Other

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents, & any care takers who can have access to this patient's records):

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

**I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT, & BILLING INFORMAITON ABOUT MY HEALTH VIA:**

**Choose only one Point of Contact:**

**Home Telephone Number (___)_____** **Cell number (___)_____**

____ OK to leave message with detailed information
____Leave message with call back numbers only

_____OK to leave message with detailed information
_____Leave message with call back numbers only
_____OK to send a text with detailed information

**Work Telephone Number (___)_____**
____ OK to leave message with detailed information
____ Leave a message with call back numbers only

**OFFICE USE ONLY**

I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was an emergency_____
- I could not communicate with the patient_____
- The patient refused to sign_____
- The patient was unable to sign_____
- Other (please describe)_____