PATIENT INFORMATION FORM

DATE _____ REFFERED BY _____

NAME _____HOME PHONE _____

CELL PHONE/ ALTERNATE_____

LOCAL ADDRESS_____CITY_____ STATE _____

ZIP CODE_____SSN_____-_____-_____ BIRTH DATE_____

SEX _____ AGE_____ EMAIL ADDRESS_____

MARITAL STATUS_____ SPOUSE /PARENT'S NAME_____

EMPLOYER _____WORK PHONE_____

PERSON TO NOTIFY IN CASE OF EMERGENCY:

NAME_____ PHONE_____

WINTER VISITORS – PLEASE GIVE ALTERNATE ADDRESS

_____PHONE_____

MEDICAL INFORMATION – PLEASE FILL OUT COMPLETELY

REASON FOR VISIT_____

DRUG ALLERGIES_____

DO YOU TAKE ASPIRIN OR ASPIRIN PRODUCT?_____FREQUENCY_____

DO YOU SMOKE CIGARETTES? ___ YES ___ NO # OF PACKS PER DAY_____

MEDICATIONS YOU ARE CURRENTELY TAKING – LIST ALL (include over the counter)

_____ _____ _____

_____ _____ _____

LIST ANY PAST FACIAL PLASTIC SURGERY_____

LIST ANY PAST SURGERY BODY_____

LIST ANY PAST ANESTHESIA_____

PROBLEMS WITH ANESTHESIA YES_____ NO_____

LIST ANY MEDICAL CONDITIONS_____

Heart_____ Lungs _____ Gastrointestinal _____ Psychiatric _____

REGULAR FAMILY PHYSICIAN_____

PLEASE READ THE ATTACHED "FINANCIAL POLICY" DISCLOSURE CAREFULLY. It will explain our policy in relation to Medicare And Insurance Companies that we have contracts with or that we participate with. After reading it carefully, please sign in the appropriate place to signify your understanding and willingness to comply with our policy.

Medication/Allergy Sheet

Name_____ Date _____

Please list all medication, latex and environmental allergies

Allergy:	**Reaction:**	**Date Reviewed:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all current medications, dosage and frequency

Medication:	**Dosage:**	**How Often:**	**Date Reviewed:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OUR FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our office manager.

Unless other arrangements have been made in advance by either you or your health coverage carrier. "FULL PAYMENT" is due at the time of service. For your convenience we accept cash, check, VISA and MASTERCARD and DISCOVER.

MEDICARE

We accept Medicare assignment, however you are responsible for the Medicare deductible and for the 20% that Medicare does not pay.

We DO file secondary insurance. We will make sure that your secondary insurance company information is sent on to Medicare with your claim. Depending upon the type of policy you have, in many cases Medicare will automatically forward all the information to your secondary carrier. **If you have a third insurance carrier it will be your responsibility to file your claim.**

It is our policy that should any insurance company send us the payment and there is NO BALANCE due on your account, we will automatically issue you a refund check. We DO NOT keep credit balances on accounts.

REGULAR INSURANCE

IT IS OUR POLICY TO COLLECT AT THE TIME OF SERVICE. **Dr. Jon Strohmeyer does participate with Blue Cross Blue Shield of Florida.** If you are covered by BCBS of Florida, you will be required to pay any co-pay, unmet deductible or non-covered service at the time of each visit. **Regardless of your insurance company's guidelines, all unpaid balances will become your full responsibility 60 days after your visit.** In the event your health plan determines a service to be NOT COVERED you will be responsible for the complete charge. Should you dispute the way YOUR insurance company handled your claim, it will be the patient's responsibility to follow-up with any appeals.

COSMETIC PROCEDURES

All cosmetic procedures must be PAID IN FULL 3 weeks BEFORE the procedure is scheduled to be performed, usually at the time of the pre-operative appointment. A $200.00 deposit is required to hold a surgery date. Cosmetic procedures are NOT COVERED by insurance and will NOT be filed to any insurance company.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand that such terms may be amended from time to time by the practice.

_____ _____

Signature of Patient or Responsible Party Date