Hilton Head
Plastic Surgery & MedSpa

David S. Reid IV, M.D.

NEW MEDSPA PATIENT REGISTRATION

(Please Print) Date_____

1. Legal Name_____Nickname_____

Age_____ Sex_____ Date of Birth_____

Local Address _____City_____Zip code_____
Home Phone _____ Mobile Phone_____

E-mail Address_____ Social Security #_____

Can this office e-mail you at this e-mail address? Yes_____ No_____

Can we call and/or leave a message at:

Home Phone? Yes____ No____ Mobile Phone? Yes____ No____Work Phone? Yes____No_____

3. Person to Notify in case of Emergency
Name_____ Relation_____
Telephone_____ Address_____
_____

4. Are you presently under the care of a physician? Yes_____ No_____

If yes, whom?_____ Address_____

5. Reason for this visit:

_____

6. Referral source: _____

Signature_____ Date_____

PLEASE NOTIFY US OF ANY CHANGE IN THE ABOVE INFORMATION.

SEE REVERSE SIDE

Hilton Head
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CONSENT FOR PHOTOGRAPHY

I, _____, consent to have photographs, videotapes, digital or audio recordings, and/or images, and any other method to reproduce or edit such likeness or image now known or hereafter developed (collectively, "**Photography**"), taken by Hilton Head Plastic Surgery and MedSpa and its staff. I understand that such Photography will be recorded for documentation and to assist with my care.

I understand that the Photography or a portion of the Photography will become part of my medical record and therefore be protected, used and/or disclosed in accordance with the practice's Notice of Privacy Practices. I further understand that Practice will own the Photography and I will not receive any fee, compensation or royalty for such Photography, but that I will be allowed to access or view the Photography or to obtain copies of any portion of the Photography that becomes part of my medical record.

I give further consent (optional) to give Hilton Head Plastic Surgery and MedSpa authorization to utilize my photos in the following manner:

-share photos with others in office (i.e., for consultative purposes); YES_____ NO_____

-share or post photos on company website and/or other promotional resources; YES_____ NO_____

-share or post photos on company social media (i.e., Facebook and or Instagram); YES_____ NO_____

I have read this consent in its entirety and agree to be bound by all its terms and conditions as described above. I acknowledge and agree that I have been given the opportunity to ask any questions and have had all my questions answered to my satisfaction.

_____ _____

Printed Patient Name Date Signature of Patient

Hilton Head Plastic Surgery MedSpa Scheduling Fee Policy

Hilton Head Plastic Surgery MedSpa prides itself on individualized care. Our providers allow ample time for consultation and treatment so as to provide the best experience possible for each patient. Providing our office with ample time to adjust for schedule changes helps us to accommodate other patients.

Hilton Head Plastic Surgery MedSpa kindly requests a minimum of 24 hrs. notice to cancel or reschedule any appointment. While we understand that schedules can sometimes change unexpectedly, patients who are unable to abide by this policy will be asked to provide credit card information in order to continue to pre-schedule appointments. A $50 fee will be charged for any missed appointment or cancellation within 24 hrs. of the appointment.

By initially below, I signify that I have read and consent to the Scheduling Fee Policy, I understand that my credit card information will be held on file & charged accordingly based on this policy.

I have read and agree to the above terms and conditions. _____ (initials)

Hilton Head
Plastic Surgery & MedSpa

David S. Reid IV, M.D.

MEDICAL HISTORY

Date_____

1. Patient Name_____ Age_____ Sex_____

Date of Birth_____ Height_____ Weight_____

Please answer yes or no to the following and indicate date if you have had or now have any of the following:

	YES	NO	DATE
a. General			
weight change	___	___	_____
bleeding disorder or easy bruising	___	___	_____
skin disease	___	___	_____
diabetes	___	___	_____
high blood pressure	___	___	_____
b. Heart & Lungs			
asthma	___	___	_____
pneumonia	___	___	_____
emphysema	___	___	_____
coughing up blood	___	___	_____
tuberculosis	___	___	_____
shortness of breath	___	___	_____
chest pain	___	___	_____
ankle swelling	___	___	_____
rheumatic fever	___	___	_____
heart murmur	___	___	_____
heart attack	___	___	_____
c. Head & Neck			
cold sores	___	___	_____
meningitis	___	___	_____
seizures	___	___	_____
paralysis	___	___	_____
deafness	___	___	_____
ear infections	___	___	_____
eye infections	___	___	_____
visual problems	___	___	_____
nosebleeds	___	___	_____
hoarseness	___	___	_____
unconsciousness due to head injury	___	___	_____

	YES	NO	DATE
d. Abdomen			
ulcers	___	___	_____
vomit blood	___	___	_____
blood in stool	___	___	_____
hepatitis	___	___	_____
jaundice	___	___	_____
e. Kidney & Genital			
pain w/urination	___	___	_____
blood in urine	___	___	_____
kidney stones	___	___	_____
syphilis	___	___	_____
f. HIV	___	___	_____
Aids	___	___	_____
g. Hand	___	___	_____
right handed	___	___	
left handed	___	___	
ambidextrous(both)	___	___	_____
h. Female			
breast lumps			
nipple discharge	___	___	_____
menstrual difficulties	___	___	_____
breast pain	___	___	_____
female relatives with breast cancer?			_____
if yes, who?			_____
age when periods began?			_____
age when periods stopped? (menopause)			_____
number of pregnancies			_____
number of miscarriages			_____
number of children			_____

SEE REVERSE SIDE

2. Serious Illnesses (list and date)

_____

_____

_____

3. Operations (list and date). Please include cosmetic procedures.

_____

_____

_____

4. Other Hospitalizations (list and date)

_____

_____

_____

5. Do you smoke (includes Cannabis, tobacco, or vaping)? Yes_____ No_____

If YES, number of packs/amount per day?_____ For how many years?_____

If NO, have you ever smoked? Yes_____ No_____

If yes, when did you stop?_____

How much alcohol do you consume per day?_____

Have you ever had a nervous breakdown? Yes___ No___If YES, when?_____

6. Serious illness of parents or other relatives? Yes___ No___

If YES, indicate problems, which relative and whether they are living or deceased.

_____

_____

_____

THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature Date

Hilton Head
Plastic Surgery & MedSpa

David S. Reid IV, M.D.

PRESCRIPTION DRUGS

Patient Name _____ **Date** _____

Preferred Pharmacy _____ **Location** _____

Allergies & Reactions: NO ALLERGIES _____

Codeinereaction_____

Penicillin_____reaction_____

Demerol_____reaction_____

Sulfa_____reaction_____

Tape/Latex_____reaction_____

Mycins_____reaction_____

Other/foods_____

- reaction_____

Please Note: Aspirin, Tylenol and nicotine are all drugs.

MEDICATION NAME	DOSAGE	FOR WHAT CONDITION?	WHEN & HOW YOU TAKE?
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.
4.	4.	4.	4.
5.	5.	5.	5.
6.	6.	6.	6.
7.	7.	7.	7.

OVER THE COUNTER MEDICATIONS: *Please include herbal and nicotine supplements.*

1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.

Hilton Head Plastic Surgery LLC - New Patient Consent to the Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment or Healthcare Operations

I, _____, understand that as part of my health care, Hilton Head Plastic Surgery, LLC, originates and maintains records, including photographs, describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,

- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been offered/provided a ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures. I have the right to request a copy of a ***Notice of Privacy Practice***. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Hilton Head Plastic Surgery, LLC, is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Hilton Head Plastic Surgery, LLC, reserves the right to change their notice and practices. Should Hilton Head Plastic Surgery, LLC, change their notice, a revised copy will be provided to you at your next office visit or at your specific request.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

A $35 service fee will be charged due to insufficient funds on all returned checks. _____ please check or initial

The bank and credit agreement below applies only to services rendered today or in the future that are paid by credit card and disputed.

It may become necessary to release your protected health information to financial parties, credit card entities, banks and/or financing companies, when requested, to facilitate your payment.
Please check or initial all highlighted areas below:

_____ Services that are performed and paid with a credit card, debit card or financing company are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Dr. David S. Reid, Hilton Head Plastic Surgery LLC to use and disclose my health information to any credit card entity, bank or financing company when they request such information to process an account and assist with payment.
_____ I will not challenge such credit, debit, or financing card payment once services are provided. This practice encourages complete post-treatment care and follow-up interaction to address any issue that may arise.
_____ I agree that this non-credit card challenge agreement is irrevocable.

I fully understand and I accept the terms of this consent.

Signature Date

Hilton Head
Plastic Surgery & MedSpa
David S. Reid, IV, M.D.

PATIENT CONSENT TO SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name (please print) _____ **DOB** _____

Please list the person(s) that we may disclose the following information:

Your past, present and future physical or mental health.

The provision of your health care.

Your past, present and future payment for health care.

The person(s) may be a spouse, family member, close friend or care-giver that can act as a liaison or trusted person to share your personal health information in your absence.

_____ _____
(Full Name) (Relationship to Patient)

_____ _____
(Full Name) (Relationship to Patient)

_____ _____
(Full Name) (Relationship to Patient)

_____ _____
(Full Name) (Relationship to Patient)

I acknowledge that this consent will remain in place until my written notification requesting a change has been received and processed.

Signature_____ Date_____