Hilton Head
Plastic Surgery & MedSpa

David S. Reid IV, M.D.

NEW PATIENT REGISTRATION

(Please Print) Date_____

1. Legal Name_____ Nickname_____

Age_____ Sex_____ Date of Birth_____

Permanent Mailing Address_____
Street or PO Box City, State, Zip

Local Address _____

Home Phone _____ Mobile Phone_____

E-mail Address_____ Social Security #_____

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

Employer_____ Occupation_____

Employer Address_____ Telephone_____

Can we call and/or leave a message at:

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

2. Marital Status (circle) Single Married Widowed Separated Divorced

Spouse_____ Spouse date of birth_____

Mobile Phone _____ Occupation_____

Employer/Address/Phone_____

_____

3. Nearest Relative to Notify in case of Emergency (other than spouse)

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 (if accident-related, please give date of accident)_____

_____

6. Referral source: _____

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IF WE HAVE MADE COPIES OF YOUR INSURANCE CARDS,

YOU DO NOT NEED TO COMPLETE QUESTIONS 6 or 7.

6. **MEDICARE MEDICAL INSURANCE**

Medicare #_____ Do you have Medicare Part A & Part B? Yes_____No_____

Do you have Secondary Insurance? Yes_____ No_____

If so, give name, address & ID # or a copy of your card_____

7. **PRIMARY INSURANCE**_____

Address & ID # or a copy of your card_____

8. **WORKMAN'S COMPENSATION**

Is this a work-related injury? Yes_____ No____ Did you report this injury to your employer? Yes____No____

Employer_____Employer Address_____

Phone #_____ Contact Person_____

PLEASE NOTIFY US OF ANY CHANGE IN THE ABOVE INFORMATION.

I authorize David Reid, M.D. to release information to the insurance companies named above if requested.
I authorize the taking of photographs to be used for medical purposes.
I understand that a fee is charged for all visits, examinations, and medical reports. Fees for cosmetic surgery are payable in advance. I understand that I am financially responsible for charges not covered by insurance.

FINANCIAL RESPONSIBILITY AGREEMENT

Payment is expected at the time of service. Payment may be made by cash, check or major credit card. Third party health insurance payments are generally accepted for services. Any deductible, co-insurance or co-payment is payable at the time of service.

Payment Guarantee

The undersigned agrees, whether signing as a patient or guarantor, to guarantee payment of the account (in accordance with the standard rates & terms) of Hilton Head Plastic Surgery, LLC. I understand that any insurance is a contract between the insurance company and myself, except in certain cases where Hilton Head Plastic Surgery, LLC has a specific contract with my PPO, HMO or other third party payer. I further understand that any balance remaining after insurance approves or denies payment is my responsibility to pay.

Cosmetic Responsibility

A 20% deposit is required to secure a surgery date (a portion of which may be withheld if surgery is cancelled). The balance is due two weeks prior to surgery and, if not paid, the surgery date will be released.

Non-Cosmetic Responsibility

Fees of $500 or less are payable one week in advance of surgery. A 20% deposit is required for fees over $500 (some participating PPO's are excluded from this policy).

Signature Date

Hilton Head
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David S. Reid IV, M.D.

MEDICAL HISTORY

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/Zip code** _____

Allergies & Reactions: NO ALLERGIES _____

Codeine_____reaction_____
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-op 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

-

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 caregiver 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_____