Lexington Plastic Surgery

Theo Gerstle, M.D.

PATIENT INFORMATION (please print) **Date:** _____/_____/_____

Dr. Mrs.
Mr. Ms.

Patient Name: _____
Last First M.I.

Address: _____
Street City State Zip

Home phone:(_____)_____ **Work phone:** (_____)_____

Cellular phone:(_____)_____ **Pager:**(_____)_____

E-mail: _____

Sex: M F **Birthdate:**_____/_____/_____ **Soc. Sec. #:** _____-_____-_____
(REQUIRED) (REQUIRED)

GUARANTOR (if someone other than the patient is responsible for the bill)

Name: _____

Address: _____

INSURANCE (if your visit is *not* cosmetic in nature)

Primary Insurance Co: _____

Name of Policyholder: _____

Relation to patient: Self Spouse Parent Other

ID#: _____ **Group #:** _____

Secondary Insurance Co: _____

Name of Policyholder: _____

Relation to patient: Self Spouse Parent Other

ID #: _____ **Group #:** _____

EMERGENCY CONTACT: _____
Name Relation Phone

Patient Name: _____ Date: _____

Dr. Gerstle is interested in knowing about your general health so he may plan your surgery / treatment as carefully as possible. This form is absolutely CONFIDENTIAL.

General health ____ Excellent ____ Good ____ Fair ____ Poor
Marital status ____ Single ____ Married ____ Divorced ____ Widowed

HEIGHT: _____ WEIGHT: _____

1. DRUG ALLERGIES? ____ None If yes, please list medication and reaction.

   Name of Medication Reaction (i.e. nausea, itching, rash, etc)
   1)_____ _____
   2)_____ _____
   3)_____ _____

2. OTHER ALLERGIES? ____ None If yes, please check all that apply.

   ___ Latex ____ Adhesive Tape ____ Contrast Dye ____ Iodine ____ Seafood
   ___ Metal ____ Other, please list _____

3. Any medications, vitamins, over-the-counter herbal preparations/supplements? ____ None
   If yes, please list below.

Name of Medication	Strength (mg)	How many times a day?	Reason for taking it

4. Have any family history of cancer, heart trouble, or stroke? Y N (Specify)
   _____

5. Engage in a regular exercise program? Y N (Specify) _____

6. Consume regular amounts of alcoholic beverages? Y N (Amount) _____

7. Use tobacco? Y N (Amount) _____
   Drug Use? Y N (Specify)_____

8. Have any current or previous use of cortisone/steroids? Y N (List)_____

9. Do you have a problem with general anesthesia? Y N (Specify) _____
   Any family member experienced problem with anesthesia? Y N (Specify) _____
   _____

Please list all surgical procedures you have undergone.

Year	Procedure	Hospital	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Name: _____ Date: _____

Please check below:

	Y	N	
GENERAL	☐	☐	Serious illness lately?
	☐	☐	Anemia
	☐	☐	Nervousness
	☐	☐	Drug habit/addiction
	☐	☐	Psychiatric treatment
	☐	☐	Blackouts or Epilepsy
	☐	☐	Shortness of breath
Thrombosis / DVT			
	☐	☐	High blood pressure
	☐	☐	Diabetes
	☐	☐	Thyroid problems
	☐	☐	Susceptible to cold sores

	Y	N	
KIDNEYS	☐	☐	Infections
	☐	☐	Kidney damage
	☐	☐	Kidney failure
BLOOD	☐	☐	Bleeding tendency
	☐	☐	Blood transfusions
	☐	☐	Blood Clots /
BREAST	☐	☐	Cyst, tumor, or lump
	☐	☐	Breast biopsy
	☐	☐	Nipple discharge
	☐	☐	Mammogram

HEART	☐	☐	Heart trouble
	☐	☐	Heart attack
	☐	☐	Palpitations/irregular or extra beats
	☐	☐	Angina (chest pain)
	☐	☐	Abnormal EKG
	☐	☐	Rheumatic heart disease
	☐	☐	Heart failure
LUNGS	☐	☐	Asthma
	☐	☐	Bronchitis
	☐	☐	Tuberculosis
	☐	☐	Pneumonia
	☐	☐	Smoker's cough
	☐	☐	Emphysema

EYES	☐	☐	Visual problems
	☐	☐	Wear contacts
	☐	☐	Wear glasses
	☐	☐	Use eye drops
	☐	☐	Other (Specify)
NOSE	☐	☐	Broken nose
	☐	☐	Difficulty breathing through the nose
	☐	☐	Use nose spray
LIVER	☐	☐	Hepatitis (Yellow Jaundice)
	☐	☐	Cirrhosis (Alcohol Disease)
INTESTINAL	☐	☐	Stomach ulcers
	☐	☐	Colitis
	☐	☐	Gallstones

Primary Care Physician – Name: _____ Phone Number: _____

Date of your last physical exam: _____
Date of most recent mammogram: _____
Any recent lab work? Y N Date: _____

How did you hear about us: Friend _____
Doctor _____
Yellow Pages _____
Internet _____

Other Comments:
(Rev 10/11)

Lexington Plastic Surgery
THEO GERSTLE, M.D.

POLICIES AND AUTHORIZATIONS RELATED TO PAYMENT

Commercial Insurance

I hereby authorize release of any and all information (including photographs) necessary to file a claim with any insurance company and assign benefits, otherwise payable to me, to the doctor indicated on the claim.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Signature of Policy Holder Date

Payment Policy

All professional services rendered are charged to the patient and are due and payable at the time of service. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, including deductibles and co-payments, regardless of insurance coverage. Past due accounts greater than thirty (30) days will be subject to an interest fee of 1.5% per month. Past due accounts may also be subject to attorney's fees, collection fees, legal fees, and / or court costs incurred as a result of our attempt to collect the debt. A service fee of $25.00 will be assessed for each returned check.

I understand that I am financially responsible for the payment of any amount not covered by my insurance carrier. A copy of this signature is as valid as the original.

_____ _____

Signature of Patient or Personal Representative Date

Lexington Plastic Surgery
THEO GERSTLE, M.D.

DISCLOSURE OF PATIENT INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

The policy of our practice is to maintain the strictest of confidentiality of your entire medical record. Therefore, we must have your written authorization to release medical information.

I hereby consent to Theo Gerstle, M.D. (the "Practice") using or disclosing my protected health information, including photographs, for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to the Practice using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals. I expressly authorize release of any records pertaining to Chemical Dependency/Substance Abuse (drugs, alcohol) and Sexually Transmitted Diseases.

I further acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by the consent, as well as other rights I have regarding my protected health information.

Signature of Patient or Personal Representative	Description of Representative's Authority
Printed Name of Patient or Personal Representative	Date

Lexington Plastic Surgery

Theo Gerstle, MD
1760 Nicholasville Rd
Bldg C Suite 402
Lexington, KY 40503

TEL: 859-279-2111
FAX: 859-899-0001

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY:

Theo Gerstle, MD

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

_____ Patient Signature

_____ Witness Signature

_____ Date

The Board requires that all identifiable characteristics, with the exception of a full face photograph or photograph of a uniquely identifiable characteristic, be blanked out for submission of materials for the Oral Examination of The American Board of Plastic Surgery to protect patient privacy.