REGISTRATION INFORMATION

NAME: _____
(LAST) *(FIRST)* *(M.I.)*

MAILING ADDRESS: _____

*CITY, STATE,ZIP:*_____

EMPLOYER: _____

*EMPLOYER ADDRESS:*_____

HOME#: ____-____-_____ CELL#: ____-____-_____ WORK#: ____-____-_____
CAN WE TEXT YOUR CELL PHONE W/ APPOINTMENTS OR SPECIALS? YES / NO

MAY WE LEAVE A MESSAGE @ HOME? _____YES_____NO
MAY WE LEAVE A MESSAGE @ WORK? _____YES_____NO
EMAIL ADDRESS: _____

DATE OF BIRTH____/____/____ SOCIAL SECURITY#: ____-____-_____
MARITAL STATUS: ____S____D____M____W

EMERGENCY CONTACT: ***(SOMEONE OUTSIDE YOUR HOME-FAMILY/FRIEND)***

NAME: _____RELATIONSHIP: _____
PHONE#: ____-____-_____

RESPONSIBLE PARTY IF OTHER THAN PATIENT:

NAME: _____

MAILING ADDRESS: _____

DAYTIME PHONE#: ____-____-_____ SOCIAL SECURITY #: ____-____-_____

HOW DID YOU HEAR ABOUT US? _____
NAME OF PERSON WHO REFERRED YOU TO US: _____

KEVIN R SNODGRASS, M.D.
PLASTIC SURGERY HEALTH HISTORY

NAME:_____ TODAY'S DATE:_____
Height_____ Weight_____ Age_____

PRESENT PROBLEM

Specific problem(s) for which you are seeking plastic surgery:_____
_____

Have you consulted any other doctors, including plastic surgeons, about this? Yes No
If yes please list their names: _____

PAST MEDICAL HISTORY

Please Circle:	Diabetes	Yes	No	Kidney	Yes	No
	Hypertension	Yes	No	Thyroid Disease	Yes	No
	Heart Disease	Yes	No	Lung Disease	Yes	No
	Stroke	Yes	No	Depression	Yes	No
	Cancer	Yes	No	Bleeding Disorder	Yes	No
	Anemia	Yes	No	Bowel Problems	Yes	No
	HIV/AIDS	Yes	No	Bladder Problems	Yes	No
	Hepatitis	Yes	No	Chest Pain	Yes	No
	Arthritis	Yes	No	Shortness of Breath	Yes	No
	Seizures	Yes	No	Memory Loss	Yes	No
	* Back Pain	Yes	No	Frequent Headaches	Yes	No
	Nausea/Vomiting	Yes	No	Varicose Veins	Yes	No
	Liver Disease	Yes	No	Blood Clots	Yes	No

**PATIENT UNDERSTANDS IMPLANTS COULD MAKE BACK PAIN WORSE _____*
Any history of sleep apnea? _____

Any other medical condition or problems?_____
Allergies:_____

Surgeries:_____ _____
_____ _____
Medications:_____ _____
_____ _____

Do you ever take- Aspirin BC Powders Goodie Powders
Ibuprofen Nuprin Advil Motrin How often? _____

Do you take any arthritis medications?_____ How often? _____

FAMILY HISTORY

Do you have a family history of (if yes list relative)	Heart Disease	No	Yes _____
	Diabetes	No	Yes_____
	Bleeding Disorder	No	Yes_____
	Stroke	No	Yes_____
	Cancer	No	Yes_____
	Blood Clots	No	Yes_____

SOCIAL HISTORY

Married_____ Single_____ Divorced_____ Widowed_____

Alcohol Usage: None_____ Rarely_____ Moderate_____ Daily_____

Tobacco Usage: Never_____ Previously, but quit _____
Yes _____ Current Packs/Day _____

Recreational Drug Usage: Never_____ Yes_____ Type/Frequency_____

FEMALE ONLY

Any problems with menstrual cycle? Yes_____ No_____
Number of pregnancies_____ Number of deliveries_____ Miscarriages_____
Have your tubes been tied? Yes_____ No_____
History of breast cancer? Yes_____ No_____
History of breast cancer in family? Yes_____ No_____
History of nipple discharge? Yes_____ No_____
History of breast biopsies? Yes_____ No_____
Do you do self breast exams? Yes_____ No_____
Have you ever had a mammogram? Yes_____ No_____
(If yes) WHEN?_____ WHERE?_____

****

Family Physician _____
Whom may we thank for referring you to our practice?_____

I UNDERSTAND THE ABOVE ANSWERS ARE IMPORTANT FOR MY SAFETY AND ARE TRUE TO THE BEST OF MY KNOWLEDGE.

Date:_____

Patient Signature:_____

Nurse Signature:_____

Physician Signature:_____

KEVIN R. SNODGRASS M.D., D.D.S., P.C.
RELEASE OF MEDICAL INFORMATION AND INSURANCE ASSIGNMENT FORM

TO MY PHYSICIAN AND INSURANCE CARRIER(S):

1. I authorize the release of any medical information necessary to process my insurance claim(s).
2. I authorize and request payment of medical benefits to my physician.
3. If I am a participant in a preferred provider arrangement or a member of a health management organization, I authorize the release of my medical information for utilization reviews and such other procedures as provided in the plan.
4. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.
5. I agree that photocopy of this form may be used in lieu of the original.
6. I understand that unless I am a participant on a preferred provider arrangement or health management organization, which may limit my liability, I am responsible for the payment of all charges that occur as a result of my medical treatment. I also understand that even if I am a participant in a preferred provider arrangement or health management organization, I still may be personally responsible for the payment of all charges that occur as a result of my medical treatment. Further, if it is determined through the Utilization Management review under such plan that any medical services that I hereafter receive are not covered under the plan, I agree that I am personally responsible for the payment of the charges that occur of said medical services, and I agree to pay the charges for said services.
7. I authorize any holder to Medigap-covered services.

_____ ____/____/_____
Signature of patient or responsible party Date

_____ _____
Patient's name printed Patient's account #

MEDICARE LIFETIME AUTHORIZATION

I authorize any holder of medical or other information about me to release it to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier and information needed for this or any related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignments. Regulations pertaining to Medicare assignments of benefits apply.

_____ ____/____/_____
Signature of patient or responsible party Date

_____ _____
Patient's name printed Patient's account #

KEVIN R. SNODGRASS, M.D.,D.D.S

CONSENT FOR MEDICAL QUALITY ASSURANCE AND PEER REVIEW

I authorize Dr. Kevin Snodgrass to disclose complete information concerning his medical findings and treatment of the undersigned, from the initial office visit until the date of the conclusion of such treatment, to those physicians and medical reviewers who, in Dr. Kevin Snodgrass' sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

_____ ____/____/_____

Signature of patient or responsible party Date

_____

Patient's name printed

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of Notice of Privacy Practices is available to me. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling 706-378-0200 or by requesting one at this office.

X_____

PRINT NAME_____

Date: _____

*If signed by a personal Representative, please state your authority to act for the Patient

_____

This space to be used by practice only.
Patient acknowledged Privacy Practices and signed office copy. Yes___ No___
If refused by patient, document in chart: _____
Note: Cannot refuse to see patient if refuses to sign.
Employee initials: _____

Effective Date: April 14, 2003
Office must keep form for 6 years from date signed beginning 4/14/03
Date: _____

KEVIN R. SNODGRASS, M.D.

RELEASE OF INFORMATION

In order to allow Dr. Kevin R. Snodgrass and employees to discuss patient information with others involved in your treatment or the payment of services rendered, such as your spouse, child, relative, friend, neighbor, care taker, etc., please provide the following information:

PATIENT INFORMATION

NAME: _____
DATE OF BIRTH: _____
SOCIAL SECURITY #: _____
PHONE NUMBER: _____

I hereby allow Dr. Kevin R. Snodgrass and employees to discuss/release my medical information, such as appointment reminders, to verify dates and times of appointments, pick up prescriptions, lab results, care or treatment needs, etc., with the following individuals [(You do not have to list three individuals. *If you do not want to list anyone's name, please write NONE on the first row)]:

1) Name _____ Phone Number_____
   Relationship to Patient_____

2) Name _____ Phone Number_____
   Relationship to Patient_____

3) Name_____ Phone Number_____
   Relationship to Patient_____

My signature below indicates I understand the following:

I may change the names of the individuals listed above at any time. Changes must be made in writing.

Signature of Patient_____ Date_____

Print Name of Patient_____

06/14/13

Credit Card HIPAA Release

Kevin R. Snodgrass, M.D. requires a signed release statement, from you, when a credit card is used to pay for a procedure. If there is ever a dispute with the credit card company regarding this transaction, then we need to have the ability to provide personal information to THAT bank or credit organization.

We value your privacy and promise that the staff of Kevin R. Snodgrass, M.D. will provide NO protected health information to the credit card unless those details are necessary to resolve a dispute.

Thank you for your cooperation.

Signature: _____

Date: _____