DIGENIS PLASTIC SURGERY INSTITUTE 502-589-5544

Patient Information as of ________________ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name ______________________________
First Middle Initial Last

Address ______________________________
Street & Apt # City State Zip

Home Phone __________ Cell Phone __________ **PREFERRED PHONE#** __________

Any restrictions for contacting you? ❒ No ❒ Yes E-mail __________

Contact Restrictions: __________ **REFERRAL SOURCE:** __________

Age ______ Birthdate / / SS# - - Sex ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: __________ ❒ Other: __________

Pharmacy phone number __________

Patient's Employer __________ Occupation __________

Work Phone __________ Ext: ______ Is it okay to call you at work? ❒ Yes ❒ No

Emergency Contact __________ Relationship to Patient __________

Home Phone __________ Work Phone __________ Other Phone __________

Primary Health Insurance Company __________

Policy # __________ Group # __________ Ins. Phone __________

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ ______

Insured: Name __________ DOB __________ Insured's SS: __________

Secondary Health Insurance Company __________

Policy # __________ Group # __________ Ins. Phone __________

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ ______

Insured: Name __________ DOB __________ Insured's SS: __________

I understand that charges are payable on the day service is rendered, and that I am financially responsible for all charges incurred in this office. I authorize ***Kentucky Aesthetic & Plastic Surgery Institute, PLLC/Dr. Alexander G. Digenis*** to bill my insurance company directly, however, this does NOT transfer my financial obligation to my insurance company. I understand that this office will bill me should my insurance company deny reimbursement, or fail to pay. I acknowledge financial responsibility for fees not paid by this assignment and agree to pay any late fees, collection agency fees, and legal fees if my account becomes delinquent. I acknowledge that I was offered a HIPAA privacy policy for this office. I hereby grant permission for the use of my medical records, including photographs, provided my identity is not revealed.

Signature ______________________________ **Date** __________

DIGENIS PLASTIC SURGERY INSTITUTE 502-589-5544

Patient Medical History

Patient Name: ___________________________Date:____________________

If you are an existing patient, has anything changed since your last visit? □**NO** **or** □**YES**

If yes, please answer the following:

Height __________________ Weight_______________
Drug Allergies and Reactions: ____
Other Allergies (i.e. latex, iodine, tape, skin sensitivity):____________________________________

Present Medications (including diet pills, vitamins, & herbal preparations):

Medication	**Times per Day**	**Milligrams**	**Reason Prescribed**

Previous Surgeries (please give year):

Surgery	**Year**

Explain any reaction you have had to anesthesia: ____

List any diseases that run in your family (i.e. cancer, heart disease, diabetes, high blood pressure, blood clots):____

Check any of the following conditions you have:

□Arthritis
□Anemia
□Bleeding Disorders
□Kidney Disease
□Poor Circulation
□HIV
□Hepatitis/Jaundice
□High Blood Pressure
□Heart Disease
□Peptic Ulcers
□Asthma
□Blood Clots
□Lung Disease
□Liver Disease

Do you drink alcohol? □No □ Yes ___________glass per week or month (circle)

Do you smoke? □No □Yes ______packs per day?

Do you take aspirin, ibuprofen, Motrin, Nuprin, Ecotrin, or Advil on a regular basis? □No □Yes
How Often?_____________per day, week or month (circle) Reason ________________

Sign up for appointment reminders on your cell phone!

3 EASY STEPS

Step 1: Make sure we have an updated cell phone number.

Step 2: Text the word Digenis to the number 622-622 (no area code).

Step 3: Wait for confirmation from Televox!