Patient Registration Form

Patient Information

Patient Name: _____ _____ _____
First Middle Last

Address: _____ _____ _____
Number/Street City/State Zip

Home #: _____Cell #: _____ Work #: _____

Email Address: _____ Employer: _____

Date of Birth: _____ _____ _____ Gender: ☐ Male ☐ Female SSN#: _____

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Native American ☐ Hispanic ☐Other

Language: ☐ English ☐ Spanish ☐ Russian ☐ Other_____

Responsible Party (Complete ONLY if the party responsible for billing is NOT the patient)

Name: _____ _____ _____
First Middle Last

Address: _____ _____ _____
Number/Street City/State Zip

Home #: _____Cell #: _____ Work #: _____

Date of Birth: _____ _____ _____ Gender: ☐ Male ☐ Female SSN#: _____

Relationship to Patient: _____

Insurance Information (Insurance cards MUST be presented to the receptionist)

Primary Insurance

Insurance Name: _____

Policy/Member #: _____

Group/Plan #: _____

Subscriber Name: _____

Sub Gender: ☐ M ☐ F DOB: _____

Secondary Insurance

Insurance Name: _____

Policy/Member #: _____

Group/Plan #: _____

Subscriber Name: _____

Sub Gender: ☐ M ☐ F DOB: _____

Patient Registration Form

Assignment and Release

I, _____, have insurance coverage and assign all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize Dr. Grant to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured /Guardian Date

Emergency Contact Information

Name: _____ Relationship: _____

Home #: _____ Cell #: _____

How Did You Hear About Us?

☐ Google/Online ☐ Patient Referral_____

☐ Billboard ☐ Dr. Referral_____

☐ NW Bridal Expo ☐ Star Kart _____

☐ Other_____

No Show & Last Minute Appointment Cancellations

Cascade Facial Surgery & Aesthetics is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at (360) 336-1947 by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday. If prior notification is not given, you will be charged $50.00 for the missed appointment prior to being rescheduled.

Please sign below to consent to these terms.

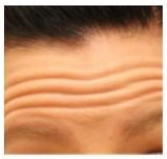
_____ _____

Patient Signature (Patient's Parent/Guardian if under 18) Date

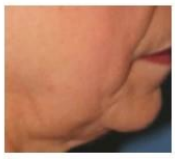
Cascade Facial Surgery & Aesthetics

Patient Interest Questionnaire

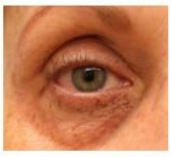
Please indicate any areas of concern for you



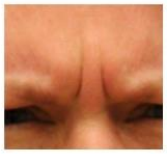
○ Forehead Lines



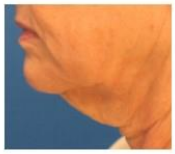
○ Jowls



○ Under eye darkness & circles



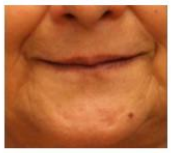
○ Frown lines



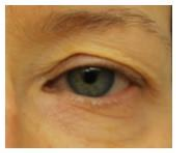
○ Neck Laxity

○ Under eye wrinkles

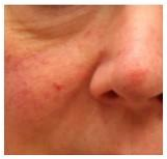
○ Crow's Feet



○ Lines around Nose & mouth



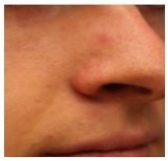
○ Upper eyelid redundant skin



○ Redness/ Rosacea

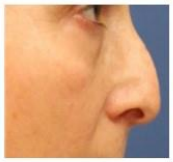
○ Recessed Chin

○ Lower eyelid puffiness

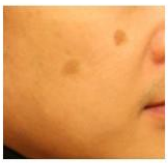


○ Pores

○ Prominent Ears

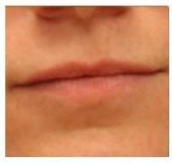


○ Nasal refinement

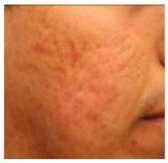


○ Pigmentation

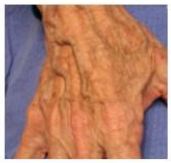
○ Ear gauge piercings



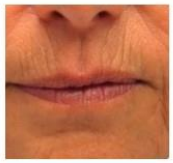
○ Thin lips



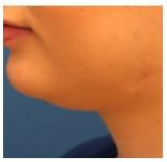
○ Scarring



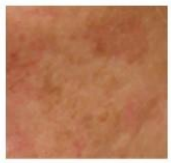
○ Hand rejuvenation



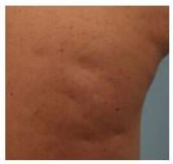
○ Upper lip lines



○ Double chin



○ Skin texture/ skincare



○ Cellulite of thighs or buttock

Name:_____ Date:_____

Health History Questionnaire

Primary Care Physician: _____ PCP Phone #: _____

Referring Provider (if different from PCP): _____

Preferred Pharmacy: _____ _____ _____
Name Street/City
Phone Number

Have you had or do you currently have any of the following medical conditions?

Conditions	Yes	No	Description
Arthritis			
Artificial Joints			
Asthma			
Atrial Fibrillation			
Bleeding Disorder			
Breast Cancer			
Colon Cancer			
COPD			
Coronary Artery Disease			
Defibrillator			
Depression			
Diabetes			
Emphysema			
Epilepsy			
Hearing Loss			
Heart Conditions (heart attack, irregular heartbeat)			
Hepatitis			
High Blood Pressure			
Hypertension			
HIV/AIDS			
High Cholesterol			
Kidney Disease			
Leukemia			
Liver Disease			
Lung Cancer			
Lymphoma			
MRSA			
Pacemaker			
Planning on Becoming Pregnant			
Problems Scarring			
Prostate Cancer			
Radiation			
Seizures			
Sleep Apnea (use CPAP)			
Stroke			
Thyroid Problems			
Tuberculosis			

Other health conditions not listed above:_____

Health History Questionnaire

Family History

Conditions	Yes	No	Description
Arthritis			
Asthma			
Bleeding Tendency			
Cancer			
Chronic Lung Disease			
Convulsions or Fits			
Diabetes			
Gout			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Leukemia			
Mental Illness			
Migraine Headaches			
Obesity			
Repeated Infections			
Severe Allergies			
Thyroid Trouble			
Tuberculosis			

Medications & Allergies

List your current **MEDICATIONS**	List your **ALLERGIES**
prescriptions, over the counter or supplements	drug allergies
☐ Check here if no current medications	☐ Check here if no known drug allergies

Previous Surgeries

Type of Surgery	Year Performed
☐ Check here if no surgical history	

Social History

Do you smoke?	Yes	No	How much?
Ever Smoked?	Yes	No	
Do you drink?	Yes	No	How much?
Do you have children?	Yes	No	How many?

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

Consent for Communication

Patient Name: <PersonalInfo.FirstName> <PersonalInfo.LastName>

Please mark how you are comfortable with us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Ok to Send Text Messages	Preferred Contact Method
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No		☐
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No		☐
Email Address: Cell Phone #:				
☐ Email Appointment Reminders ☐ Text Appointment Reminders				
Which do you prefer? ☐ Email Appointment Reminder ☐ Text Appointment Reminder				
☐ Email Newsletters				
☐ Email Office Specials				

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Discuss Patient Information	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature:_____ Date:_____

HIPAA Information and Consent Form

Patient Name: <PersonalInfo.FirstName> <PersonalInfo.LastName>

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Signature:_____ Date:_____

Photo Consent

I, ____<PersonalInfo.FirstName> <PersonalInfo.LastName>_____ grant permission to Cascade Facial Surgery & Aesthetics staff to use photographs of me for demonstration and educational purposes. I authorize the use of both pre and post procedure photographs to demonstrate the changes that Cascade Facial Surgery & Aesthetic services can achieve. In order to use these photographs and discuss the medical services provided, I do hereby waive my provider-patient privilege. I understand, however, that confidences unrelated to the procedures will not be disclosed. I have indicated below the extent of usage that I approve for my pre and post procedure photographs.

I do further hereby release Cascade Facial Surgery & Aesthetics and staff from any and all claims regarding damages for libel, slander, invasion of privacy or other claims based upon the use of the above described material.

***All photos are cropped to show the treatment area only. This is to obscure the identity of our patients.**

Please initial:

_____Approval for use during physician consultations with clients seeking like services.

_____Approval for use in Cascade Facial Surgery & Aesthetics display & marketing books.

_____Approval for use on Cascade Facial Surgery & Aesthetics website & social media websites.

_____Decline to use photos for anything other than private medical chart.

Computer Imaging Disclaimer:

Computer imaging may be used to better educate you about your upcoming surgery. Although an approximation of intended results is to be displayed, I realize that there are differences in graphic artistic ability and surgical technique. I realize that computer imaging does not constitute and should not be construed to be an exact representation of post-surgical results. I understand that it is impossible to guarantee intended results. I understand that the alteration of any images is purely for the purpose of education, illustration and discussion.

_____ __<Appointment.Date>_

Patient Name Printed Date

_____ __<Appointment.Date>_

Patient/Parent or Legal Guardian Signature Date