PTCH #: 18373

NEW HORIZONS CENTER FOR COSMETIC URGERY

9843 Gross Point Road Skokie, Illinois 60076
Gregory A. Turowski, M.D., Ph.D.
Aditya Sood, M.D., M.B.A.

PATIENT INFORMATION

Last Name:	Legal First Name:	Middle Initial:	Today's Date:
Marital Status:		Gender:	
SS#:	Driver's License # or State ID#:	Age:	Birth Date:

PLEASE SELECT PREFERRED METHOD OF CONTACT:

□ Home Phone #:	□ Work Phone #:	□ Cell Phone #:	□ *Email Address:	
Home Address:		City:	State:	Zip Code:
Employer Name: & Address:		City	Zip Code	Occupation:
Patient/Guardian/Guarantor Name: & Address:		City	Zip Code	Birth Date: SS#:
In case of emergency contact: (Name)		*Relationship*:	*Home Phone#*	*Cell Phone #*

REASON FOR CONSULTATON

(Chief Complaint)

□ Cosmetic / Self Pay

□ Non Cosmetic / Insurance

□ Both

□ _____

□ _____

□ _____

REFERRAL SOURCE

(How did you hear of New Horizons Center?)

□ I am a prior patient

□ Patient: (Name)

□ Physician: (Name)

□ Internet: (Website)
_____

□ Other: (Name)_____

PCP

Primary Care Physician

□ Physician Name & Address:

Phone #

Fax #

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**By providing my e-mail address, I am authorizing NHCCS , its physicians, and staff to communicate with me electronically about my appointments, care, account, NHCCS service surveys, NHCCS products and services, and/or education.*

INSURANCE INFORMATION

(Please provide insurance card for photocopy)

Primary Insurance		***Secondary Insurance***	
Name of Insurance Company:		Name of Insurance Company:	
Subscriber's Name:	Birth Date:	Subscriber's Name:	Birth Date:
Policy #:	Group #:	Policy #:	Group #:

AUTHORIZATION

(A photocopy of these authorizations and assignment shall be considered as valid as the original)

Assignment and Release:

I hereby consent for New Horizons Center for Cosmetic Surgery to provide me with medical treatment. I authorize the release of medical information contained in my chart to me, and/or the insured's insurance company, and/or payment card in order to process any bill or billing dispute. I authorize the use of and disclosure of my private health information for the purpose of: Treatment, Payment, Billing Dispute and Healthcare Operations. I authorize payment from my, and/or the insured's insurance company and/or payment card directly to New Horizons Center for Cosmetic Surgery

_____ _____

Signed: (Patient/Legal Guardian) Date:

Collections:

By signing, I hereby authorize that in the event of becoming delinquent in payment or services rendered by New Horizons Center for Cosmetic Surgery, that collection agency fees of 30% and any court costs (if applicable) will be added to the balance and will be patient's or guardian's responsibility. Additionally, I understand and accept that New Horizons Center for Cosmetic Surgery will try to notify via phone or letter prior to foregoing the formalities and repercussions associated by a collection service. Should my account be referred to an outside collection agency, I agree to pay the collection fees in addition to the delinquent balance.

_____ _____

Signed: (Patient/Legal Guardian) Date:

AUTHORIZATION
Medical Photographs/Slides/Videotapes

Instructions

This is a consent document that has been prepared to help inform you concerning **permission to take photographs**, slides, and/or videotapes and to use these images for a purpose as defined within the consent document. It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by New Horizons Center for Cosmetic Surgery.

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Consent to take photographs/slides/videotapes			
I hereby authorize New Horizons Center for Cosmetic Surgery and/or his/her associate or licensees to take preoperative, intraoperative and postoperative photographs, slides, and/or videotapes. I additionally consent to photographs, slides and/or videotapes of my interview.			
_____	_____	_____	_____
Signed: (Patient/Legal Guardian)	Date:	Witness:	Date:

MEDICAL HISTORY FORM

(Please provide accurate information. This report is strictly confidential)

History of Illness	*Yes*	*No*		*Yes*	*No*
Major Medical Illness			Heart Problems		
Major Trauma/Injury			Irregular Heart Beat		
Bleeding Disorder			Chest Pains		
Blood Transfusions			High Blood Pressure		
Diabetes			Heart Attack		
Liver Disease			Cancer		
Lung Disease			Stomach Ulcers		
Asthma			Bowel Disease		
Bronchitis			Neurological Problems		
Varicose Veins			Skin Diseases		
Blood Clots/Embolism			HIV or AIDS		
Paralysis/Stroke			Vision Problems		
Please Explain Yes Answers:					
Please explain your family medical history:					

Screening questionnaire for Latex sensitivity	*Yes*	*No*	
Have you ever been told that you are allergic to Latex or products containing rubber?			If so when?
Do you have any allergic symptoms while in contact with latex?			If so please list all.

Allergies and Medications	*Yes*	*No*		
Do you have any allergies?			Please list all:	
Do you take any medications? Include prescription/over the counter (Aspirin, Tylenol, vitamins, herbs, and dietary aid supplements)			Medication Name & Dose:	How Often:
Social Habits				
Do you smoke cigarettes?			How long (years):	How many (per day):
Do you drink Alcohol?			How many (glasses per day):	
Do you or have you used drugs/narcotics for recreational purposes?			□ Heroin □ Cocaine □ LSD □ Other	
Have you ever taken steroids?			□ Cortisone □ Prednisone	
Surgeries and Hospitalizations				
Have you ever had past surgeries / hospitalizations?				
Please Explain:				
Have you had a tetanus injection?			If so, date of injection:	
Do you bruise easily, heal poorly or scar badly?			Please explain:	

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Have you ever received counseling for a mental condition, depression, or emotional problem?			Please explain:
If female, is there a possibility that you may be pregnant?			Date of last menstrual period: