KELLING PLASTIC SURGERY
PATIENT REGISTRATION INFORMATION

FIRST _____ **MI** ____ **LAST** _____ **SS#** _____

ADDRESS _____ **PHONE** _____

CITY _____ **STATE** _____ **ZIP** _____

SEX: **M** ☐ **F** ☐ **AGE** _____ **BIRTH DATE** _____ **MARITAL STATUS:** **S** ☐ **M** ☐ **W** ☐

E-MAIL ADDRESS _____ **CELL** _____

EMPLOYER _____ **EMPLOYER PHONE** _____

OCCUPATION _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

WHO REFERRED YOU TO OUR PRACTICE _____

WHAT ARE YOU BEING SEEN FOR TODAY _____

NEAREST FRIEND OR RELATIVE NOT AT THE SAME ADDRESS _____

PHONE # _____ **DO YOU HAVE MEDICAL INSURANCE?** **YES** ☐ **NO** ☐

PRIMARY INSURANCE _____ **PHONE#** _____ **BIRTHDATE** _____

INSURED NAME _____ **ID #** _____ **GRP #** _____

PLEASE HAVE ALL INSURANCE CARDS AND DRIVERS LICENSE AVAILABLE FOR COPYING. ALL PATIENTS PLEASE READ THE FOLLOWING DISCLOSURE AND SIGN.

IN ORDER TO CONTROL OUR COST OF BILLING, WE REQUEST PAYMENT BE MADE AT THE TIME SERVICE IS RENDERED.

AUTHORIZATION: I HEREBY AUTHORIZE DR. KELLING FOR A PERIOD OF TEN YEARS, TO FURNISH AND/OR ELECTRONICALLY TRANSMIT ANY BILLING AND/OR MEDICAL RECORD INFORMATION TO INSURANCE CARRIERS, ATTORNEYS, ANY THIRD PARTY MEDICAL RECORD RETRIEVAL SERVICE, OR ANY ENTITY NECESSARY IN THE COLLECTION OF FEES IN REGARD TO THIS ILLNESS/TREATMENT. I HEREBY IRREVOCABLY ASSIGN TO DR. KELLING ALL PAYMENTS FOR MEDICAL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

PATIENT SIGNATURE _____ **DATE** _____

RESPONSIBLE PARTY SIGNATURE _____ **DATE** _____

PLEASE LET US KNOW IF YOU WOULD BE INTERESTED IN LEARNING ABOUT ANY OF THE FOLLOWING PROCEDURES:

Facelift ☐ Breast Lift ☐ Eyelid Surgery ☐ Liposuction ☐ Nose Surgery ☐

Tummy Tuck ☐ Breast Augmentation ☐ Other Cosmetic Surgery ☐

JOSEPH A. KELLING, MD

MEDICAL HISTORY

PLEASE ANSWER ALL QUESTIONS. IF A QUESTION DOES NOT PERTAIN TO YOUR MEDICAL HISTORY OR THE ANSWER IS NO, PLEASE MARK NO IN THE AREA PROVIDED OR MARK N/A. THANK YOU.

NAME _____ **DATE** _____

DATE OF LAST PHYSICAL EXAM _____ **PRIMARY DOCTOR** _____

OB-GYN _____

SURGERY (COSMETIC AND NON-COSMETIC)

	TYPE	DATE	COMPLICATIONS OR DIFFICULTIES
1)			
2)			
3)			

ADMISSIONS TO HOSPITAL

	REASON	DATE	COMPLICATIONS OR DIFFICULTIES
1)			
2)			
3)			

MEDICATIONS (ANY DRUG OR MEDICINE) YOU TAKE NOW

	TYPE	DOSAGE	HOW OFTEN TAKEN
1)			
2)			
3)			

CONSUMPTION OF THE FOLLOWING

ASPIRIN _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

ALCOHOL _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

TOBACCO _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

HERBAL SUPPLEMENTS **YES** ☐ **NO** ☐ **LIST** _____

VITAMINS **YES** ☐ **NO** ☐ **LIST** _____

BLEEDING PROBLEMS

DO YOU BRUISE OR BLEED EASILY? **YES** ☐ **NO** ☐

DO YOU HAVE A FAMILY HISTORY OF BLEEDING PROBLEMS? **YES** ☐ **NO** ☐

DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA? **YES** ☐ **NO** ☐ **EXPLAIN** _____

MEDICAL PROBLEMS OR CONDITIONS NOW UNDER TREATMENT BY A PHYSICIAN:

_____

JOSEPH A. KELLING, MD

HAVE YOU EVER BEEN EXPOSED TO:

YES ☐ NO ☐ INTRAVENOUS DRUGS
YES ☐ NO ☐ INFECTIOUS DISEASES
YES ☐ NO ☐ TB
YES ☐ NO ☐ AIDS
YES ☐ NO ☐ HEPATITIS

HISTORY OF EPILEPSY OR MENTAL ILLNESS? **YES** ☐ **NO** ☐ **EXPLAIN** _____

CHILDHOOD MEDICAL HISTORY

HAD ALL KNOWN "BABY SHOTS" YES ☐ NO ☐ UNCERTAIN ☐
HAD POLIO IMMUNIZATION YES ☐ NO ☐ UNCERTAIN ☐
HAD RHEUMATIC FEVER YES ☐ NO ☐ UNCERTAIN ☐

FAMILY HISTORY

ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESSES? **YES** ☐ **NO** ☐

MOTHER _____ **FATHER** _____

SISTER _____ **BROTHER** _____

REVIEW OF SYSTEMS

ANY SIGNIFICANT MEDICAL PROBLEMS WITH ANY OF THE FOLLOWING? (Mark all that are applicable)

☐ HEAD; IF YES EXPLAIN:
☐ EYES; IF YES EXPLAIN:
☐ EARS, NOSE, THROAT; IF YES EXPLAIN:
☐ THYROID; IF YES EXPLAIN:
☐ LUNGS; IF YES EXPLAIN:
☐ HEART; IF YES EXPLAIN:
☐ BLOOD PRESSURE OR VESSELS; IF YES EXPLAIN:
☐ DIGESTIVE SYSTEMS; IF YES EXPLAIN:
☐ LIVER; IF YES EXPLAIN:
☐ MUSCLES, BONES; IF YES EXPLAIN:
☐ REPRODUCTIVE ORGANS; IF YES EXPLAIN:
☐ KIDNEYS, BLADDER; IF YES EXPLAIN:
☐ UNSIGHTLY SCARS; IF YES EXPLAIN:
☐ DISEASE AFFECTING IMMUNE SYSTEM; IF YES EXPLAIN:
☐ URINARY INCONTINENCE; IF YES EXPLAIN:
☐ OTHER; IF YES EXPLAIN:

WOULD YOU LIKE A REFERRAL FOR ANY OF THESE PROBLEMS? **YES** ☐ **NO** ☐

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATIONS? **YES** ☐ **NO** ☐ **PLEASE LIST** _____

ARE YOU PREGNANT? **YES** ☐ **NO** ☐

PREGNANCY HISTORY _____

JOSEPH A. KELLING, MD

Acknowledgement of Receipt
Notice of Privacy Practices

To Our Patients,

The privacy of your health care information is extremely important to us. We want you to understand how we use and disclose your information and your rights to this information. We ask you to review our Notice of Privacy Practices that describes our legal duties with respect to your health care information.

How we use health care information:

We use information about you to:

*Provide treatment to you
*Ensure appropriate payment for the treatment we provide
*Monitor the quality of our operations

When we may disclose information:

In certain limited cases we are permitted to disclose health care information about you. Examples include when there is a serious threat to health or safety, for insurance reimbursement, to reduce public health risks, for health oversights and in certain cases for law enforcement. In addition, we may disclose information to tell you about health-related services and alternative treatments, and to conduct health-related research with your permission.

Your informational rights:

We create a record of the care we give you.

- You have the right to know how we use your health information, whom we can give it to, and your rights to this information. (Please see our Notice of Privacy Practices)
- You have the right to ask us to restrict uses and disclosures where we believe such restrictions will not harm you and where it is possible for us to do so.
- You have the right to confidential communication of your health information. For example, you can ask for a conversation to be held in private or for us to send a copy of your bill to a different address.
- You have the right to look at and get a copy of information in our records unless your doctor has indicated this would be harmful to you or someone else.
- You have the right to request that our records be amended if we agree it is inaccurate or incomplete.
- You have a right to ask us for a list when we have disclosed your health information to someone other than those treating you, handling your bills, for our internal operations, or when you have authorized release of information.

Please sign below that you have received our Notice of Privacy Practices. If you have any questions, please speak to your physician or our office manager at 214-827-2530.

Signature: _____ **Date:** _____

Print Name: _____ **Social Security #:** _____

JOSEPH A. KELLING, MD

Release of Information

Name: _____ **Date of Birth:** _____

I authorize the release of my medical information including any claims information to the following person(s):

- ☐ Spouse: _____
- ☐ Child(ren): _____
- ☐ Other: _____
- ☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Print Name: _____

Signature: _____

Date: _____

JOSEPH A. KELLING, MD