PLASTIC SURGEONS OF ALASKA

Daniel Suver, MD
James Lee MD
Aaron Berhanu, MD
Kerry Latham, MD
Aesthetic and Reconstructive Plastic Surgeons of Alaska, LLC

Please print the following information.

Full Legal Name			Preferred Name		Today's date
Mailing Address	City	State	Zip	DL# & State	
*Please provide **physical address** if mailing address is a P.O. Box:*					
Age	Birthdate	SSN	Marital Status	Gender	
Mobile Phone:			**Home Phone:**		
E-mail:					
Occupation:			Employer:		
Emergency Contact:			Relationship:		
Emergency Contact Number:					
If Patient is a Minor:					
Parent or Guardian Name:					
Relationship to Minor:			Mobile Phone:		
Alternative Phone:					

PAYMENT FOR OFFICE VISITS OR OFFICE PROCEDURES IS REQUIRED AT THE TIME OF THE APPOINTMENT. ONCE AVAILABLE, AN ESTIMATE OF THE CHARGES INVOLVED WILL BE GIVEN.

Primary Insurance Company:		
Insured Party**:**	ID No:	Group No:
Ins Company Address:		
Secondary Insurance Company:		
Secondary Insured Party:	ID No:	Group No:
Ins Company Address:		

PLEASE PROVIDE COPIES OF INSURANCE CARDS

Patient Name: ____ **Age:** ____________________

Reason for office visit today: (Please specify area of concern)

____

Known medical problems: ____

Previous surgeries: ____

Height: _________________________ **Weight:** __________________________

Date of most recent mammogram: _________________ **Bra band & cup size:** _________________

Family history of breast cancer: (Maternal or paternal, age at diagnosis)

____

Number of children, age of youngest child, & method of delivery:

____

Allergies: *Please check one*
_______ I have no medication allergies
_______ I have medication allergies. Please list and describe what happens:

____
____

Current Medications: (including aspirin, non-prescription medications, vitamins and naturopathic medications)

Preferred Pharmacy : __________________________

Pain Management: *Please check one*
_______ No, I am NOT currently taking opioid or narcotic medications for pain.
_______ Yes, I am currently taking opioid or narcotic medications for pain. ***(If yes, please list above)***

Do you use any nicotine products? YES NO

ASSIGNMENT AND RELEASE

I hereby irrevocably authorize my insurance company/ fund to pay benefits for services directly to Plastic Surgeons of Alaska, LLC. If I have not paid in full myself. Furthermore, I understand that I am financially responsible for costs associated with my treatment. I also authorize Plastic Surgeons of Alaska, LLC to release any information required to process a claim, including but not limited to insurance companies, health care service plans, worker's compensation carriers and government services.

Patient Signature:____ Date_________________________

If patient is a minor:
Parent/Guardian Signature ______________________________________ Date___________________________

Relationship to minor: _______________________

PRIVACY

I understand the Federal Government has placed restrictions on the exchange/release of patient medical information. In cooperation with these regulations and to facilitate better and more rapid exchange of information, I offer consent to the release of information to other treating physicians or health care providers, hospitals, my insurance company (or other payers), or collection agencies in matters of payment dispute. I understand this information may be exchanged via mail, fax, other electronic media (e-mail), telephone or orally. All attempts will be made to keep this information strictly confidential. I acknowledge the notice of Privacy Practices has been made available to me and I understand that I may request a paper copy.

FURTHERMORE, I HEREBY AUTHORIZE DR. COLE, DR. SUVER, DR. LEE, DR. BERHANU OR THE OFFICE STAFF TO TAKE AND MAINTAIN PRE & POST OPERATIVE PHOTOGRAPHS AS A PART OF MY MEDICAL CHART.

Patient Signature:____ Date_________________________

If patient is a minor:
Parent/Guardian Signature ______________________________________ Date___________________________

Relationship to minor: ________________________