plastic surgeons of alaska

**Michael D. Manuel, M.D.**
**Jana K. Cole, M.D.**
**Daniel W. Suver, M.D.**
**Aesthetic and Reconstructive**
**Plastic Surgeons of Alaska, LLC**

**2741 Debarr Rd, Suite C-215**
**Anchorage, AK 99508**
**Phone: (907) 563-2002**
**Fax: (907) 562-7628**
**Referring Doctor: _____**

Thank you for choosing our office. In order to serve you properly, PLEASE PRINT the following information.

| | | | | | | |
|---|---|---|---|---|---|---|
| Name: | | | Nickname: | | Today's date | |
| Address: | | City | State | Zip | DL# & state | |
| AGE: | Birthdate: | SSN: | Height: | Weight: | Marital Status: | Gender: |

| | May we contact you here? | | May we leave a message ? | |
|---|---|---|---|---|
| Home Ph: | YES | NO | YES | NO |
| Work Ph/Ext : | YES | NO | YES | NO |
| Cellphone: | YES | NO | YES | NO |
| May we text message you? Yes or No | | | | |

**E-mail:**
May we email you information about the office or your appointments? Yes or No

| | |
|---|---|
| Occupation: | Employer: |
| Address: | |
| Spouse's Name, Occupation and Employer | |
| Emergency Contact Name: | Relationship: |
| ER Contact Home Ph: | ER Contact Work Ph: |

| | | |
|---|---|---|
| If patient is a minor: | Father's Name: | Work Phone |
| Father's Employer: | | |
| Mother's Name: | | Work Phone: |
| Mother's Employer: | | |

**PAYMENT FOR OFFICE VISITS OR OFFICE PROCEDURES IS REQUIRED AT THE TIME OF THE APPOINTMENT. WHEN POSSIBLE AN ESTIMATE OF THE CHARGES INVOLVED WILL BE GIVEN AND YOU WILL BE PROVIDED A RECEIPT FOR FILING WITH YOUR INSURANCE.**

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

**PLEASE PROVIDE COPIES OF INSURANCE CARDS**

**OVER**

# MEDICAL INFORMATION

**PATIENT NAME:** _____

**REASON FOR OFFICE VISIT TODAY (PLEASE BE SPECIFIC)**_____

_____

**REFERRED BY (NAME OF PHYSICIAN OR FRIEND)**_____

**IF INJURED, DATE OF INJURY**_____**DID THIS OCCUR AT WORK?**_____

**HAVE YOU SEEN DR. MANUEL, DR. COLE OR DR. SUVER BEFORE?**_____

**IF SO, WHEN?**_____

**NAME OF USUAL PHYSICIAN**_____

**PAST SURGERY**_____

_____

**KNOWN MEDICAL PROBLEMS (IF NONE , WRITE NONE)**_____

_____

_____

**DO YOU SMOKE CIGARETTES OR USE TOBACCO PRODUCTS? YES( ) NO( )**

**HAVE YOU BEEN TESTED FOR THE HIV (AIDS) VIRUS? YES( ) NO( )**

**RESULTS**_____**DATE OF TEST**_____
**TO YOUR KNOWLEDGE HAVE YOU BEEN EXPOSED TO HIV? YES( ) NO( )**

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

**SIGNATURE OF PATIENT OR GUARDIAN**_____**DATE**_____

**PATIENT NAME**_____

**DATE**_____

**Medication ALLERGIES: please check**
**_____ I have no medication allergies.**
**_____ I have medication allergies. Please list and describe what happens:**

_____

_____

_____

_____

**What medications do you take? (include aspirin, non prescription medications, vitamins and natural pathic medications )**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

**Other:**

## 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'S 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). 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.**

**PATIENT'S SIGNATURE:**_____ **DATE**_____

***IF PATIENT IS A MINOR:***

***PARENT/GUARDIAN SIGNATURE***_____ ***DATE***_____

***RELATIONSHIP TO MINOR***_____