



Patient Information as of \_\_\_\_\_ (enter today's date)

Patient Name \_\_\_\_\_

Birth date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Gender \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

E-mail \_\_\_\_\_  Please check if you would like to be removed from our mailing list.

Any restrictions for contacting you?  No  Yes Contact Restrictions: \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced  Separated  Partner  Other \_\_\_\_\_

How did you hear about Gardner Plastic Surgery? (Mark all that apply)

Gulfshore Life Magazine  Yellow Pages Web: www. \_\_\_\_\_

Friend/Relative, Please name \_\_\_\_\_  Doctor, Please name \_\_\_\_\_

Other \_\_\_\_\_ If you were referred by a specific person, may we thank them?  Yes  No

**Personal Background**

Employer/ School: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Responsible Party or Emergency Contact**

Full Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Birth date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_

I, \_\_\_\_\_, authorize payment of Medical Benefits to Paul M. Gardner, MD, FACS, and agree to release information necessary for processing. I agree to be responsible for payment of services and reasonable costs of collection. I authorize the release of my Medical Records to Paul M. Gardner, MD, FACS.

Signature of Patient: \_\_\_\_\_

## Medical History Record

Reason for visit (chief complaint) \_\_\_\_\_

If symptoms present, please explain and state when they first appeared

### Past History:

Previous surgeries and

dates: \_\_\_\_\_

Previous anesthetic/surgical problems: \_\_\_\_\_

### General Medical History (Please circle YES or NO):

Yes/No- high blood pressure

Yes/No- heart disease or attack

Yes/No- chest pain or shortness of breath

Yes/No- stroke

Yes/No- asthma

Yes/No- glaucoma, double vision, eye pain

Yes/No- history of deep venous thrombosis (blood clot)

Yes/No- depression, anxiety, mood swings, loss of appetite

Yes/No- back pain, joint pain/swelling, numbness of arms or legs

Yes/No- easy bruising, swollen lymph glands

Yes/No- have you taken ibuprofen, aspirin, or blood thinning agents in the past two weeks? (avoid for two weeks before and after surgery)

Yes/No- do you have prolonged bleeding when cut? (e.g. Hemophilia) If yes, please explain: \_\_\_\_\_

Yes/No- have you formed excessive or unsatisfactory scars in the past? Keloids?

Yes/No- Have you ever received treatment for a mental condition, emotional problem or depression?

Yes/No- herpes or cold sores

Yes/No- fainting or blackout episodes

Yes/No- ulcer disease or abdominal problems

Yes/No- hepatitis If so, circle A B or C

Yes/No- HIV or AIDS

Yes/No- diabetes

Yes/No- Other significant illness? If so, please describe: \_\_\_\_\_

Yes/No- excessive thirst or hunger

Yes/No- seizures, loss of balance or slurred speech

### Current Medications (list all including aspirin, birth control, vitamins and/or supplements):

Medication

Dose/Strength

Frequency taken

Medication	Dose/Strength	Frequency taken

Yes/No- Do you smoke? If yes, \_\_\_\_\_ packs per day

Yes/No- Did you ever smoke? If yes, \_\_\_\_\_ years ago

Yes/No- Do you drink alcohol? If yes, \_\_\_\_\_ drinks per day/week or only occasional.

### Allergies: (Please list any and all) \_\_\_\_\_

Any additional information not listed on this form we should know about? \_\_\_\_\_

I attest the above history is completed to the best of my knowledge and understand and accept that my failure to disclose any of the above information can adversely affect a prescription course of treatment to meet my goals, my safety, or the outcome of any treatment I elect to undergo with Dr. Gardner and/or any member of staff.

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_

**Insurance Information:**

**Primary Insurance:**

Insurance Name: \_\_\_\_\_ Policy # \_\_\_\_\_

Group # \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_

**Secondary Insurance:**

Insurance Name: \_\_\_\_\_ Policy # \_\_\_\_\_

Group #: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_

**Please Present Insurance Cards to Front Desk**

**Gardner Plastic Surgery, Inc**

Financial Policy

**Medicare Part B:**

Dr. Gardner of Gardner Plastic Surgery, Inc is a Medicare Part B Provider. He will accept assignment on all Medicare Part B Claims. By accepting assignment, he agrees to adjust your charges to reflect the Medicare approved amount for charges. However, Medicare pays 80% of the approved charges and the remaining 20% of the charge is the patient's responsibility. If you have supplemental insurance, we will bill your supplemental insurance for the 20% balance. If there is any remaining balance after the Medicare and supplemental insurance payment, this balance is the patient's responsibility.

**Private Health Insurance/Managed Care Networks:**

Dr. Gardner is a participating provider with BCBS Florida, Community Health Partners, and other insurance companies. We will file claims to insurers contracted with these organizations. Co-pays, co-insurance and/or deductibles will be due at the time of service.

At this time Dr. Gardner is an out of network provider for some other private insurances. Please check with your insurance policy for out of network services & any out of network fees for which you may be billed. Please understand that your insurance reflects a contract between you and your insurance company, not Gardner Plastic Surgery, Inc. You, as the patient, are ultimately responsible for your bill. Dr. Gardner has agreed to accept the UCR (usual, reasonable, & customary) fee determined by your insurance company as his fee for your service & waive the balance of his charges for you, but depending on your contract with your insurance company, you are responsible for a portion of this charge. Gardner Plastic Surgery, Inc will check your out-of-network benefits & file a claim as a courtesy to you; however, you will be charged the full amount of the UCR fee, and your insurance company will reimburse you for a portion of the charge depending on your contract with your insurance policy.

**Non-Covered Services:**

Not all services are covered by all health insurance plans. Services not covered or considered payable by the insurance company become the patient's responsibility.

**Gardner Plastic Surgery, Inc**

Financial Policy

I have read and fully understand this information and I agree to accept financial responsibility for any unpaid balances on my account. I understand that Dr. Gardner will file a claim as a courtesy to me, but I am ultimately responsible for any charges incurred at the time of service.

I request that payment of authorized Medicare benefits be made on my behalf to Gardner Plastic Surgery, Inc for any services furnished me by Paul M. Gardner, MD.

I hereby assign & transfer any insurance benefit due me for the professional services that I have received to Gardner Plastic Surgery, Inc, Paul M. Gardner, MD.

I authorize the release of any medical information necessary to process my Medicare &/or insurance claims.

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Signature of Patient

Date

**For patients with Medigap coverage only: (Secondary Insurance)**

I request the payment of authorized Medigap benefits be made either to me or on my behalf to Gardner Plastic Surgery, Inc. for any services furnished to me by Paul M. Gardner, MD. I authorize any holder of medical information about me to release to

\_\_\_\_\_ (name of Medigap insurer)

Any information needed to determine these benefits or the benefits payable for related services can be released.

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Signature

Date