ETPS
East Tennessee Plastic Surgery

Date _____

GENERAL INFORMATION

Name: _____ Gender: _____ DOB: ___- ___- ___ Age: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Social Security # _____ Marital Status: Married ____ Single ____ Divorced ____

EMPLOYMENT

Patient's Employer _____ Work Phone (_____) _____

Patient Occupation _____

Spouse Name (or parents if minor) _____ Cell Phone (_____) _____

EMERGENCY CONTACT

Emergency Contact (other than spouse) _____ Relationship to Patient _____

Phone number (_____) _____

CONTACTING YOU

There may be occasions in which our office needs to contact you concerning your appointment, diagnostic testing results, billing problems, any information pertaining to special services or promotions currently being offered at the office, or any other situation relating to your visit at our office. Please read and answer the following:

East Tennessee Plastic Surgery has permission to contact me by the options checked below:

Home _____ Cell _____ Text _____ Work _____ Email _____

HOW DID YOU HEAR ABOUT US

Please Circle the options that apply:

Our Website Instagram Previous Patient: _____

Google Facebook Friends / Family: _____

Doctor: _____

AREAS OF CONCERN / INTERESTS

Please select any areas of interest / concern listed below. We look forward to taking care of all your concerns!

Loose Skin or Excess Fat

1. Abdomen
2. Arms
3. Back
4. Buttocks
5. Eyes
6. Face
7. Mommy Makeover
8. Neck
9. Thighs

Breasts:

1. Too Small
2. Too large
3. Drooping
4. Uneven
5. Desire for implant removal
6. Male Excess Chest Tissue

Face:

1. Thin / Missing lashes
2. Low Brows
3. Small Chin
4. Facial / Neck Aging
5. Ear Projection / Lobes / Other
6. Hollow Areas
7. Heavy upper eyelids
8. Lower eyelid bulges

Skin:

1. Wrinkles
2. Pigmentation Problems
3. Skin Texture Problems
4. Skin Tightening
5. Bad scars
6. Skin Care Products:
   -Obagi
   - Skin Ceuticals

MEDICAL HISTORY

Primary Care Physician _____ **Office Phone Number** (_____) _____

Last date of visit to Primary Care Physician: _____

Other Physicians you have seen in the last 3 years and reason for visit:

_____

_____

History- Past and Current Problems: □ No Medical Problems □ Anxiety/Depression

□ High blood pressure □ Blood clot/clotting disorders □ Stroke □ Heart attack □ Heart arrhythmia □ Heart disease □ HIV

□ COPD □ Asthma □ Covid □ GERD □ GI Disease □ Obesity □ Migraines □ Diabetes □ Thyroid □ Abnormal Labs

□ Auto Immune Type □ Cancer – types: _____ □ Other: _____

Current medications – *prescription and non-prescription with doses:*

_____

_____

Do you take Aspirin? Yes **_____** No **_____** Reason _____ Prescribing Physician: _____

Do you take: (circle all that apply) Ibuprofen Turmeric Flax Seed Fish Oil Vitamin E *or* **None**

Other supplements/vitamins: _____

Allergies to medications: □None *or* list with reaction

_____

Allergic to Latex: □Yes □No

Past Surgical History:

_____

_____

_____

Family Medical History:*(Please check any known illness and list relation such as parents, siblings, grandparents)*

Illness:

□ Cancer (Type) _____ □ Diabetes _____

□ Strokes _____ □ Blood Clots _____

□ High Blood Pressure _____ □ Heart Disease _____

Social History:

Current Nicotine Use: No Yes **/**Packs per day**_____** Past Use**: _____** Cessation Date: **_____** Vape: Yes No

Drug Use History: Yes/Type _____ No ____ **Alcohol Use:** Yes _____ Amount: _____ No _____

Timothy S. Wilson, MD, Medical Doctor and Plastic Surgeon

Megan C. Jack, MD, Medical Doctor and Plastic Surgeon

Nancy Killgore, ANP-BC, Adult Nurse Practitioner, Board Certified and Registered Nurse

The above listed practitioners hold licensure by the State of Tennessee. A recent change to legislation involving patient communication requires that you be made aware of your practitioner's full name and licensure. Your signature below acknowledges that you have been advised of this information. We know you have the option of many physicians for your medical needs and appreciate the opportunity to serve you.

Initials _____

East Tennessee Plastic Surgery Referral Program

- All patients are eligible to participate
- Referral credit is $25 for any injectable patient and $100 for any surgery patient
- There is no cap on the amount of referral credits one patient may receive
- Referral credit may be granted up to two people max (credit will be split amongst the two)
- Credit will be issued once the referred patient has a service. The credit will expire in one year from date of issue. It may be used towards any services at East Tennessee Plastic Surgery including surgeons fee, injectables and/or skincare.
- Referral credit is non-transferrable
- The patient must sign a waiver agreeing to participate in the referral program. Agreeing to participate does not mean that any identifying or personal information will be shared. The signed waiver grants permission for our office to notify the recommending party that they now have a referral credit at our office

***Referral Program Waiver*:** I agree to participate in the East Tennessee Plastic Surgery referral program. I am aware by signing I grant permission for the office to notify the recommending person(s) that they now have a referral credit.

Initials _____

Referred by (only list two please): _____ _____

Photo Consent

I hereby consent that the practitioners at East Tennessee Plastic Surgery may photograph me for diagnostic or pre/post-operative comparison purposes. This is not consent for the release or use of photographs that are taken.

Initials _____

Signature _____ DOB: _____ Date _____

GENERAL AUTHORIZATION – ALL PATIENTS PLEASE READ AND SIGN

ASSUMPTION OF RESPONSIBILITY: the undersigned, whether he/she signs as an agent or as a patient, agrees to pay East Tennessee Plastic Surgery all fees for services rendered. This includes services rendered at our office and practice/surgeon fees for services rendered at an outside facility. Should the account be referred for collection, the undersigned shall pay all reasonable fees and collection expenses. All delinquent accounts will be assessed interest at the legal rate. It is understood that bills are payable within 30 days of receipt. I have read and understand the above information. It is understood that all injectable service payments are due the day of procedure.

Signature _____ Date _____

ALL COSMETIC PATIENTS – PLEASE READ AND SIGN

A **NONREFUNDABLE** deposit of $500 is required to schedule surgery. The remaining surgery balance is due four weeks before your surgery. If you cancel surgery after the balance is paid in full, $500 or 25% of the surgeon's fee (whichever is greater) will be forfeited. If you need to reschedule surgery before the balance is due, a second deposit of $500 is required. We accept cash, checks, and all major credit cards. We also accept Care Credit. Any refunds on credit cards or Care Credit will be assessed a 3.5% refund fee. **East Tennessee Plastic Surgery** will **NOT** file health insurance or provide information for the patient to file health insurance on any procedure or surgery that is paid for as cosmetic by the patient. **You will receive more detailed policies with your quote**. I have read and understand the above information regarding payments to East Tennessee Plastic Surgery.

Signature _____ Date _____

ALL INSURANCE PATIENTS – PLEASE READ AND SIGN

ASSIGNMENT OF INSURANCE BENEFITS: I/We hereby guarantee payment of all charges incurred for the account of the above said patient from the date of first treatment until discharge or termination of treatment. I/We hereby assign all insurance benefits to be paid to East Tennessee Plastic Surgery, P.C. I understand that I am responsible for any deductible and co-insurance. I authorize the release of my medical records to the insurance company for the determination of benefits. All non-covered expenses will be considered cosmetic and applicable policies will apply. I have read and understand the above information.

Signature _____ Date _____

MEDICARE and MEDICARE HMO PATIENTS – PLEASE READ AND SIGN

I request that payment of authorized Medicare benefits be made to East Tennessee Plastic Surgery for any covered services furnished to me by a provider at ETPS. I authorize the release of my medical records to Medicare for benefits to be determined. I understand that I am responsible for my deductible and 20% of the allowable Medicare charges (if not covered by my secondary insurance carrier or if I do not have secondary insurance). All non-covered procedures will be considered cosmetic and applicable policies will apply. I also request that payment of authorized Medigap benefits be made on my behalf to above listed provider and authorize release of medical information required to determine.

Signature _____ Date _____

INSURANCE

Primary Insurance _____ Policy Holder DOB _____

Primary Insurance Policy Holder Name _____ Policy Holder SS# _____

Primary Group Number: _____ Primary ID Number: _____

Secondary Insurance _____ Policy Holder DOB _____

Secondary Insurance Policy Holder Name_____ Policy Holder SS# _____

PRIVACY POLICY

I have had the opportunity to review the privacy policy and have been offered a written copy of this policy.

Signature _____ Date _____