

# MATTHEW J. TROVATO, M.D.

ACCOUNT #

Please help us assure you the highest quality of care by answering carefully.

## PATIENT REGISTRATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Preferred method of contact: \_\_\_\_\_

Date of birth: \_\_\_\_\_ SSN: XXX-XX-\_\_\_\_\_ Sex: Male  Female

Marital status: Married  Single  Separated  Divorced  Widowed

Emergency contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Personal physician: \_\_\_\_\_ Speciality: \_\_\_\_\_

## TODAY'S VISIT

Age on this visit: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Occupation: \_\_\_\_\_

Reason for consultation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Whom may we thank for this referral? \_\_\_\_\_

## MEDICAL HISTORY

Please check appropriate box(es) if you currently have, or have had, any of the following:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Abnormal or excessive bleeding     | <input type="checkbox"/> Blood disorders(anemia, etc.) | <input type="checkbox"/> Hepatitis          |
| <input type="checkbox"/> Fainting or blackout episodes      | <input type="checkbox"/> Thyroid problems              | <input type="checkbox"/> Swelling of ankles |
| <input type="checkbox"/> High blood pressure                | <input type="checkbox"/> Fever blisters                | <input type="checkbox"/> Cancer             |
| <input type="checkbox"/> Ulcer disease                      | <input type="checkbox"/> Skin disorders                | <input type="checkbox"/> Seizures           |
| <input type="checkbox"/> Heart disease and/or heart attack  | <input type="checkbox"/> Burning, dry, itchy eyes      | <input type="checkbox"/> Diabetes           |
| <input type="checkbox"/> Irregular heart beat, palpitations | <input type="checkbox"/> Immune disorders              | <input type="checkbox"/> Liver disease      |
| <input type="checkbox"/> Kidney problems                    | <input type="checkbox"/> Heart murmur                  | <input type="checkbox"/> Keloids            |
| <input type="checkbox"/> Lung/respiratory problems          | <input type="checkbox"/> Heart valve disorders         | <input type="checkbox"/> Sleep apnea        |

If you answered yes to any of the above, please explain: \_\_\_\_\_

\_\_\_\_\_

Are you pregnant? Yes  No  How many pregnancies have you had? \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_

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## CURRENT MEDICATIONS

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_  
Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_  
Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_  
Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_  
Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_  
Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

## SURGICAL HISTORY

### COSMETIC:

Breast \_\_\_\_\_  Face \_\_\_\_\_  Eye \_\_\_\_\_  
 Body contouring \_\_\_\_\_  Nose \_\_\_\_\_  Ear \_\_\_\_\_

### OTHER:

Gallbladder \_\_\_\_\_  Abdominal \_\_\_\_\_  Tonsils \_\_\_\_\_  
 Appendix \_\_\_\_\_  Orthopedics \_\_\_\_\_  Eyes \_\_\_\_\_  
 OB/GYN \_\_\_\_\_  Hysterectomy \_\_\_\_\_  Heart \_\_\_\_\_  
 Sinus/nose \_\_\_\_\_  Breast \_\_\_\_\_  Other \_\_\_\_\_

Have you or anyone in your family had a reaction to general anesthesia? Yes  No

If yes, please explain: \_\_\_\_\_

Has anyone in your family had breast cancer before the age of 50? Yes  No

If yes, please explain: \_\_\_\_\_

## SCARRING, BLEEDING AND TRANSFUSIONS

Have you formed excessive or unsatisfactory scars in the past? Yes  No

If yes, give locations: \_\_\_\_\_

Have you taken aspirin or blood thinners within the past two weeks? Yes  No

If yes, please list: \_\_\_\_\_

Have you had any prolonged bleeding when cut or is it in your family history? Yes  No

Have you had a blood transfusion: Yes  No  If yes, when? \_\_\_\_\_

Have you experienced a reaction to a transfusion? Yes  No  If yes, please describe: \_\_\_\_\_

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## ALLERGIES

Medication and type of reaction: \_\_\_\_\_

Food: \_\_\_\_\_

Latex:     Tape/type: \_\_\_\_\_     Soap(s): \_\_\_\_\_

## PERSONAL HEALTH HABITS

Do you use any tobacco products? Yes  No  If yes, how often? \_\_\_\_\_

Do you drink alcohol? Yes  No  If yes, how often? \_\_\_\_\_

Do you take any diet pills, natural herbs or health food supplements? Yes  No

If yes, please list: \_\_\_\_\_

Have you been on any steroids in the last year? Yes  No  If yes, please list: \_\_\_\_\_

## NEWSLETTER CONSENT

Would you like to receive invitations to special events?      Yes  No

## PHOTO CONSENT

Photographs will be taken before and after surgery for documentation. We would like to ask your permission to use these photographs to show to future patients, and *possibly* on our website gallery. This gives patients a realistic idea of the results they can expect should they choose to have a similar procedure. Rest assured that your identity will be kept confidential.

*Please initial the following:*

\_\_\_\_\_ Yes, you may use my photos to show future patients.

\_\_\_\_\_ No, please do not use my photos.

I acknowledge that photographs may be taken of my body in connection with the medical services to be performed by my physician. I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

Patient/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## PRIMARY INSURANCE

Insurance company: \_\_\_\_\_  
Insured: \_\_\_\_\_ Relation to the patient: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: Male  Female   
Policy number: \_\_\_\_\_ Group number: \_\_\_\_\_  
Insurance claim address: \_\_\_\_\_  
Pre-certification phone number: \_\_\_\_\_

## SECONDARY INSURANCE

Insurance company: \_\_\_\_\_  
Insured: \_\_\_\_\_ Relation to the patient: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: Male  Female   
Policy number: \_\_\_\_\_ Group number: \_\_\_\_\_  
Insurance claim address: \_\_\_\_\_  
Pre-certification phone number: \_\_\_\_\_

## ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits for private insurance (not to include Medicare, unless specific arrangements have been made) to Dallas Plastic Surgery Institute. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by the office staff. I hereby authorize said assignee to release all information to secure the payment.

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

Dr. signature: \_\_\_\_\_ Date: \_\_\_\_\_

# MATTHEW J. TROVATO, M.D.

## ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND OR HEALTH BENEFITS PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATE ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND OR HEALTH BENEFITS PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE.

I hereby assign and convey directly to the above named healthcare provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above named healthcare provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary insurer, and/or attorney to release to the above named health care provider any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named healthcare provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort reason insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above named health care provider (including any rights to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by the above named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damage arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me (2) submit evidence; (3) make statements about facts of law (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it were the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

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

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## ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as part of the provision of healthcare services, Dallas Plastic Surgery Institute creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care and treatments.

I have been provided with Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the Notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised Notice to the address I provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and audition functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosure have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must agree to any restriction on the use and disclosure of my Protected Health Information that I request in writing, when I request in writing, agree to terminate any restrictions on the use and disclosure of my Protected Health Information which have been previously agreed upon.

*Patient's name printed:* \_\_\_\_\_

*Patient/guardian signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_

*Witness signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_