REGIONAL PLASTIC SURGERY CENTER & Spa

Referring Physician: _____

Date of Appointment: _____

- □ Denton Watumull, M.D.
- □ Bruce Byrne, M.D.
- □ Joshua Lemmon, M.D.
- □ Derek Rapp, M.D.
- □ Chase Derrick, M.D.
- □ Chirag Mehta, M.D.
- □ P.T. Swamy, M.D.

PATIENT REGISTRATION

Section 1: PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Marital Status: □ Married □ Single □ Divorced □ Separated □ Widow

Sex: □ Female □ Male Date of Birth: _____/_____/_____ Age: _____

Social Security Number: _____ Driver's License Number: _____

Home Address: _____

City: _____ State: _____ Zip: _____

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

Email: _____

Please add me to your email list for Events and Spa Specials: □ Yes □ No

Student Status: □ Full Time □ Part Time □ Not a Student

Section 2: INSURANCE

GUARANTOR (Primary Insured):

Last Name: _____ First Name: _____ Middle Initial: _____

Guarantor's Address if different from Patient's: _____

City: _____ State: _____ Zip: _____

Relation to Patient: _____ Sex: □ Female □ Male

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

Email: _____

Date of Birth: ____/____/____ Social Security Number: _____

Driver's License Number: _____ Email: _____

Employer: _____ Work Phone: (_____) _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

Employment Status: □ Full Time □ Part Time □ Not Employed/ Retired

Occupation: _____

PRIMARY: Carrier: _____ **SECONDARY**: Carrier: _____

Policy/ID #: _____ Policy/ID #: _____

Group#: _____ Group #: _____

Effective: _____ Effective: _____

Copay: _____ Copay: _____

Patient Name: _____ Date of Birth: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize Regional Plastic Surgery Center to furnish information to insurance carriers concerning my illnesses, accidents, and treatments, and also assign to them all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I also understand that any additional copay, coinsurance, and/or deductibles are due at the time of service.

This office will request a surgery deposit of $250.00. In case of overpayment, you will be refunded after your insurance pays the surgery bill. ACCOUNT NOT PAID IN 90 DAYS WILL GO TO OUR COLLECTION AGENCY.

REGIONAL PLASTIC SURGERY CENTER NO-SHOW POLICY:
Our policy is to charge $50 for no-shows to office appointments if we do not have a 24-hour notification of cancellation; and $100 for no-shows to office surgery if we do not have a 48-hour notification of cancellation.

_____ _____ _____
Patient's signature or responsible party Date

I (We) voluntarily request Dr. _____ as my physician, and such associates, technical assistants, and other health care providers they need necessary.

_____ _____ _____
Patient's signature or responsible party Date

Section 3: EMERGENCY CONTACT (Any person not residing with patient)

Name: _____ Relation to Patient: _____

Address: _____

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

Email: _____

CONTACT CONSENT

I, _____ the undersigned patient, authorize Regional Plastic Surgery Center to contact me at the following numbers:

Via Phone:				**Can Leave Message:**	
At Home:	□ Yes	□ No	Number: (_____) _____ - _____	□ Yes	□ No
Cell Phone:	□ Yes	□ No	Number: (_____) _____ - _____	□ Yes	□ No
At Work:	□ Yes	□ No	Number: (_____) _____ - _____	□ Yes	□ No

Other Persons We May Leave a Message With:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Section 4: NEW PATIENT INFORMATION

Age: _____ Are you RIGHT or LEFT handed? □ Right □ Left

Reason for Today's Visit: _____

_____

Date of Injury (if applicable): _____ Height: _____ Weight: _____

Prior treatment or studies for this problem: _____

_____

_____

Referred by: _____ Primary Doctor: _____

PAST MEDICAL HISTORY:

Melanoma	□ Yes	□ No	Cancer	□ Yes	□ No	Kidney Disease	□ Yes	□ No
Heart Disease	□ Yes	□ No	Asthma	□ Yes	□ No	Thyroid Disease	□ Yes	□ No
Stroke	□ Yes	□ No	AIDS or HIV	□ Yes	□ No	Bleeding Tendency	□ Yes	□ No
Anemia	□ Yes	□ No	Hepatitis	□ Yes	□ No	High Blood Pressure	□ Yes	□ No
Tuberculosis	□ Yes	□ No	Gout	□ Yes	□ No	Mitral Valve Prolapse	□ Yes	□ No
Diabetes	□ Yes	□ No	High Cholesterol	□ Yes	□ No	Bad Scarring/Keloids	□ Yes	□ No
Lung Problems	□ Yes	□ No	Stomach Ulcer	□ Yes	□ No			

Do you have SLEEP APNEA? □ Yes □ No

Have you had BLOOD CLOTS (DVT, pulmonary embolism): □ Yes □ No

Other conditions/problems: _____

_____

PRIOR OPERATIONS:

Tonsillectomy	□ Yes	□ No	Gastrointestinal	□ Yes	□ No	Hand or Arm	□ Yes	□ No
Appendectomy	□ Yes	□ No	Hysterectomy	□ Yes	□ No	Heart	□ Yes	□ No
Kidney/Bladder	□ Yes	□ No	Hernia Repair	□ Yes	□ No			

Other operations: _____

_____

FAMILY HISTORY:

Breast Cancer	□ Yes	□ No	High Blood Pressure	□ Yes	□ No	Depression	□ Yes	□ No
Heart Disease	□ Yes	□ No	Diabetes	□ Yes	□ No	Bleeding Problem	□ Yes	□ No
Arthritis	□ Yes	□ No	Kidney Disease	□ Yes	□ No			

Do you smoke? □ Yes □ No How much? _____ How many years? _____

If you quit smoking, when did you quit? _____

Do you drink alcohol? □ Yes □ No If yes, □ rarely □ socially □ daily □ heavily

Do you take any non-prescription or illicit drugs? □ Yes □ No

Patient Name: _____ Date of Birth: _____

Do you have any of the following problems?

Weight Change	□ Yes	□ No	Swollen Feet	□ Yes	□ No	Seizures	□ Yes	□ No
Dry Eyes	□ Yes	□ No	Skin Rash	□ Yes	□ No	Joint/Muscle Pain	□ Yes	□ No
Chronic Cough	□ Yes	□ No	Chronic Diarrhea	□ Yes	□ No	Swollen Lymph Nodes	□ Yes	□ No
Chest Pain	□ Yes	□ No	Jaundice	□ Yes	□ No	Easy Bleeding	□ Yes	□ No
Rapid Heartbeat	□ Yes	□ No	Depression	□ Yes	□ No	Easy Bruising	□ Yes	□ No
Shortness of Breath	□ Yes	□ No						

Do you have any medication allergies? □ Yes □ No
(Hives, welts, severe itching, facial/oral/airway swelling)

If yes, please list: _____

_____

Do any medications cause adverse side effects for you? □ Yes □ No

If yes, please list: _____

_____

List all current medications (including over-the-counter/herbal):

_____

_____

_____

Are you currently working? □ Yes □ No Job Title: _____

If yes, in what capacity? □ Full Time □ Part Time □ Light Duty

Do you have any current work restrictions? □ Yes □ No

If yes, please explain: _____

_____

_____ _____ _____

Patient's signature or responsible party Date

Reviewed: _____ Date: _____

Dr. Watumull Dr. Lemmon Dr. Byrne Dr. Rapp Dr. Derrick Dr. Mehta Dr. Swamy

Patient Name: _____ Date of Birth: _____

Date: _____

To Whom It May Concern:

I authorize the release of all my medical records with your office to:

☐ Dr. Denton Watumull ☐ Dr. Joshua Lemmon ☐ Dr. Chase Derrick

☐ Dr. Bruce Byrne ☐ Dr. Derek Rapp ☐ Dr. Chirag Mehta ☐ Dr. P.T. Swamy

LOCATIONS:

☐ Richardson ☐ Los Colinas ☐ Rockwall ☐ Sherman ☐ McKinney

_____ _____ _____

Patient's signature or responsible party Date

3201 E. President George Bush Frwy, Ste 101
Richardson, Texas 75082
972-470-5000
972-470-5007 Fax

6750 N. MacArthur, Ste 257
Irving, Texas 75039
972-470-5000
972-470-5007 Fax

5236 W. University Dr., Ste 3600
McKinney, Texas 75071
972-470-5000
972-470-5007 Fax

1407 Ridge Road, Ste 101
Rockwall, Texas 75087
972-470-1000
972-772-9561 Fax

1111 E. Sara Swamy Dr
Sherman, Texas 75090
903-893-6311
903-870-0456 Fax

Patient Name: _____ Date of Birth: _____

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiner, including physician assistants and acupuncturists, may be reported for investigation to the following address:

Texas State Board of Medical Examiners
Attn: Investigations
Centre Creek Drive, Suite 300
Austin, Texas 78714-9134
1-800-201-9353