



Plastic & Reconstructive Surgery

Tony L. Weaver, DO

Dear Patient,

We would like to take this opportunity to thank you for choosing Huntsville Hospital Plastic & Reconstructive Surgery for your health care needs and to welcome you to our office. We are pleased that you have chosen us to provide you with medical services.

Our website (hhplasticsurgery.org) should help answer any questions you have about our office. We want you to know about our office services and what to expect at the time of your first visit.

Please complete the enclosed forms prior to your appointment. Please bring them with you on your appointment date, along with your identification cards, insurance cards and medication list, as well as your co-payments and/or deductibles.

If you are unable to keep this appointment or if you are going to be more than **15 minutes** late, please call our office at (256) 265-6851 as soon as possible. We will be happy to reschedule a more convenient time for you.

We look forward to seeing you and if you have any questions, please do not hesitate to call our office.

Sincerely,



Tony L. Weaver, MD
Huntsville Hospital Plastic & Reconstructive Surgery

401 Lowell Drive, Ste. 12
Huntsville, AL 35801
o: (256) 265-6851
f: (256) 265-6869

Patient

Date: _____

Name: _____ Referred by: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

DOB: _____ SSN: _____ Sex: M F

Email address: _____

Patient's occupation: _____ Employer: _____

Employer's address: _____ Employer phone: _____

Spouse's name: _____ Spouse's DOB: _____ Spouse's SSN: _____

Spouse's occupation: _____ Employer: _____

Employer's address: _____ Employer phone: _____

In case of emergency, notify: _____ Relationship: _____

City: _____ State: _____ Phone: _____

If patient is a minor, list person/s other than emergency contact above who have permission to bring child to office for treatment:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Insurance *(provide patient information unless patient is a minor, then provide guarantor's information)*

PRIMARY INSURANCE

Insurance name: _____ Relationship to patient: _____
Subscriber's name: _____ Copay amount: _____
Subscriber ID/Contract Policy #: _____ Group #: _____
Subscriber's SSN: _____ Subscriber's DOB: _____
Subscriber's Employer: _____ Employer's Phone: _____

SECONDARY INSURANCE

Insurance name: _____ Relationship to patient: _____
Subscriber's name: _____ Copay amount: _____
Subscriber ID/Contract Policy #: _____ Group #: _____
Subscriber's SSN: _____ Subscriber's DOB: _____
Subscriber's Employer: _____ Employer's Phone: _____

Person responsible for this account: _____ Phone: _____

I agree payment will be made at the time of service. I agree to pay all copays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs and attorney's fees. I authorize HH Plastic & Reconstructive Surgery to release information to insurance carriers and for insurance carries to release information to HH Plastic & Reconstructive Surgery concerning my illness, treatment and payments (including worker's compensation) and I hereby assign to the physician all payments for medical services rendered to myself or my dependents if assignment applies.

Signature Date Time

Date: _____

Appointment with: _____

Name: _____

Date of birth: _____ Age: _____

What other doctors/specialists do you see? Name/Specialty: _____

Reason for visit: _____

Any new or worsening problems? If yes, please describe: _____

PAST MEDICAL HISTORY *(Please check if you have any of the below.)*

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Goiter | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Thyroid Nodule |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes - Type 1 | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes - Type 2 | <input type="checkbox"/> Infertility | <input type="checkbox"/> Valvular Heart Disease |
| <input type="checkbox"/> Autoimmune Disease (Lupus) | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Insomnia | <input type="checkbox"/> UTI - Recurrent |
| <input type="checkbox"/> Biliary Cirrhosis | <input type="checkbox"/> DVT (Blood Clot in Legs) | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Varicose Veins/Phlebitis |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Eczema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Abnormal Pap Smear |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> GI Bleed | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Breast Disease |
| <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> GERD (Acid Reflux) | <input type="checkbox"/> MI (Heart Attack) | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Hemochromatosis | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Cervical Cancer |
| <input type="checkbox"/> CVA/Stroke | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Gestational Diabetes |
| <input type="checkbox"/> COPD (Lung Disease) | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Rh Sensitized |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> PVD | Using a CPAP? Yes / No |
| | | <input type="checkbox"/> PUD (Stomach Ulcers) | |

Other _____

PAST SURGICAL HISTORY

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Cataract Extraction | <input type="checkbox"/> Kyphoplasty | <input type="checkbox"/> Prostate Surgery |
| <input type="checkbox"/> AV Fistula Creation | <input type="checkbox"/> Colon Resection | <input type="checkbox"/> Mitral Valve Replaced | <input type="checkbox"/> Shoulder Surgery
Right / Left |
| <input type="checkbox"/> AV Graft | <input type="checkbox"/> Craniotomy | <input type="checkbox"/> Nephrectomy
Right / Left | <input type="checkbox"/> Sleep Apnea Surgery |
| <input type="checkbox"/> Aortic Valve Replacement | <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Pacemaker Implanted | <input type="checkbox"/> Thyroid Surgery |
| <input type="checkbox"/> Aortic Valve Replaced | <input type="checkbox"/> Gallbladder Removed | <input type="checkbox"/> Parathyroidectomy | <input type="checkbox"/> Tonsil's Removed |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> Pneumonectomy
Right / Left | <input type="checkbox"/> Vascular Surgery |
| <input type="checkbox"/> Both Legs Bypassed | <input type="checkbox"/> Hip Replacement
Right / Left | <input type="checkbox"/> PTCA (Angioplasty) | <input type="checkbox"/> Breast Augmentation
Right / Left |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Invasive Pain Procedure | <input type="checkbox"/> Rotator Cuff Repair
Right / Left | <input type="checkbox"/> Mastectomy
Right / Left |
| <input type="checkbox"/> Bronchoscopy (Lung Scope) | <input type="checkbox"/> Kidney Transplant
Right / Left | <input type="checkbox"/> Abdominal Hysterectomy | <input type="checkbox"/> Lumpectomy
Right / Left |
| <input type="checkbox"/> CABG (Heart Bypass) | <input type="checkbox"/> Knee Arthroscopy
Right / Left | <input type="checkbox"/> Ovaries Removed
Yes / No | |
| <input type="checkbox"/> Carotid Endarterectomy | <input type="checkbox"/> Knee Replacement
Right / Left | | |
| <input type="checkbox"/> Carpal Tunnel
Right / Left | | | |

Other _____

Patient name: _____

DOB _____

FAMILY HISTORY

	Father	Mother	Brother	Sister	Children
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Artery Disease/Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease (Chronic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (Type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY (Check or circle appropriate)

Married Single Divorced Widowed

Work Part-Time Full-Time Retired Disabled Occupation: _____

Children: Yes / No Religious Affiliation _____

ALLERGIES OR MEDICATION REACTIONS

NO KNOWN DRUG ALLERGIES

Allergic to: _____ Reaction: _____

RISK FACTORS (Check or circle appropriate)

Current tobacco use Year started _____
Type of tobacco: Cigarettes / Cigars / Snuff / Vapor

Former tobacco use Year quit _____

Never smoked
Second hand smoke Yes / No

Do you wear a seat belt? Yes / No

Multiple sexual partners? Yes / No

Caffeine Use Yes / No

How many drinks per day _____

Alcohol use Yes / No

How many per day? _____ Type _____

Exercise Yes / No

Times per week _____ Type _____

CURRENT MEDICATIONS

REFER TO LIST

REFER TO BOTTLES

Please include the dose and how often you take the medication. (Skip if you brought a list or bottles)

Name	Dosage	How many times per day?	As Needed (PRN)

Pharmacy _____ Phone# _____ Location _____

Do we have permission to receive medication history on patient via electronic prescription? Yes / No

Signature of patient/guardian _____ Date _____

Patient name: _____

DOB _____

MEDICAL PROBLEMS Have you had any recent or persistent problems with the following?

General

- Weight Gain/Loss
- Fever/Chills/Fatigue
- Snoring
- Sleep Troubles
- Depression/Anxiety

Neuro

- Headache
- Head injury
- Blackouts/Dizzy
- Seizures/Tremors
- Memory Loss
- Numbness/Tingling
- Forgetfulness/Confusion
- Abnormal Coordination

Urinary

- Frequency
- Trouble starting or stopping urine stream
- Blood In Urine
- Painful Urination
- Urinating at Night
- Urine Leakage
- Unable to Urinate

ENT

- Allergies
- Sinus Congestion
- Glasses/Contacts
- Blurred Vision
- Ringing
- Hoarseness
- Runny Nose
- Hearing Loss
- Trouble Swallowing
- Neck Lump
- Swollen Glands
- Earache

Skin

- Rashes
- Abnormal moles
- Changes in Hair/Hair Loss
- Wounds that will not heal

Heart

- Chest Pain
- Palpitations
- Shortness of Breath
- Ankle Swelling

Lungs

- Persistent Cough
- Cough Up Blood
- Shortness of Breath
- Wheezing

Women

- Irregular Periods
- Pelvic Pain
- Nipple Discharge
- Lumps In Breasts
- Frequent Sweats/Hot Flashes
- Vaginal Discharge

Musculoskeletal

- Joint Pain
- Gout
- Varicose Veins
- Leg Swelling
- Back Pain
- Joint Stiffness
- Muscle Weakness
- Muscle Pain
- Muscle Cramps

Gastrointestinal

- Reflux/GERD
- Vomiting
- Diarrhea
- Constipation
- Bloody/Black Stool
- Hemorrhoids
- Loss of Appetite
- Rectal Bleeding
- Abdominal Pain

Sexual

- Problems with sex
- Erectile Dysfunction
- Painful Intercourse
- Decreased Sexual Desire
- Blood in Semen

Endocrine

- Excessive Thirst
- Excessive Urination
- High Blood Sugars
- Heat Intolerance
- Cold Intolerance

Please enter the most recent date and results of the following:

	Date	Results	Performed by (who/where)
Colonoscopy	_____	_____	_____
Pap Smear	_____	_____	_____
Mammogram	_____	_____	_____
Bone Density Scan	_____	_____	_____
Menstrual Period	_____	_____	_____
PSA (Prostate Screen)	_____	_____	_____
Eye Exam	_____	_____	_____

When was your last vaccine on the following:

	Date	Would you like one?
Flu Vaccine	_____	Yes / No
Tetanus Vaccine	_____	Yes / No
Pneumonia Vaccine	_____	Yes / No
Shingles Vaccine	_____	Yes / No

Patient Name: _____ SSN (opt): _____

Date of Birth: _____ Address: _____

Phone: _____ Date of Service: _____

Chart #: _____

Provider: _____

I authorize the use or disclosure of the above named individual's health information as described below:

- Huntsville Hospital Physician Network is authorized to make the disclosure.
- The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

<input type="checkbox"/> All/entire record	<input type="checkbox"/> Consultation report	Records release format: (choose one)
<input type="checkbox"/> Visit/encounter notes	<input type="checkbox"/> Operative report	
<input type="checkbox"/> Laboratory results	<input type="checkbox"/> Immunization record	<input type="checkbox"/> e-delivery
<input type="checkbox"/> X-ray and imaging reports	<input type="checkbox"/> Drug and alcohol treatment	(HealthPort connect)
<input type="checkbox"/> Problem list	<input type="checkbox"/> HIV/AIDS/STD treatment	<input type="checkbox"/> CD
<input type="checkbox"/> Medication list	<input type="checkbox"/> Registration record	<input type="checkbox"/> Paper
<input type="checkbox"/> Allergies list	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> EKG report		
<input type="checkbox"/> Pathology report		

I understand the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndroms (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or agency:

Name: _____ Address: _____

for the purpose of: _____

I understand that I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand the revocation will not apply to information already released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, the authorization will expire on the following date, event or condition:

If left blank, this authorization will expire six months from the date of signing.

- I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.
- I understand as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.
- I understand I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan or eligibility for benefits. HOWEVER, I understand that if I refuse to sign this form, under specific conditions the organization can refuse treatment enrollment in the health plan and/or eligibility for benefits.

Signature _____ Date _____ Time _____

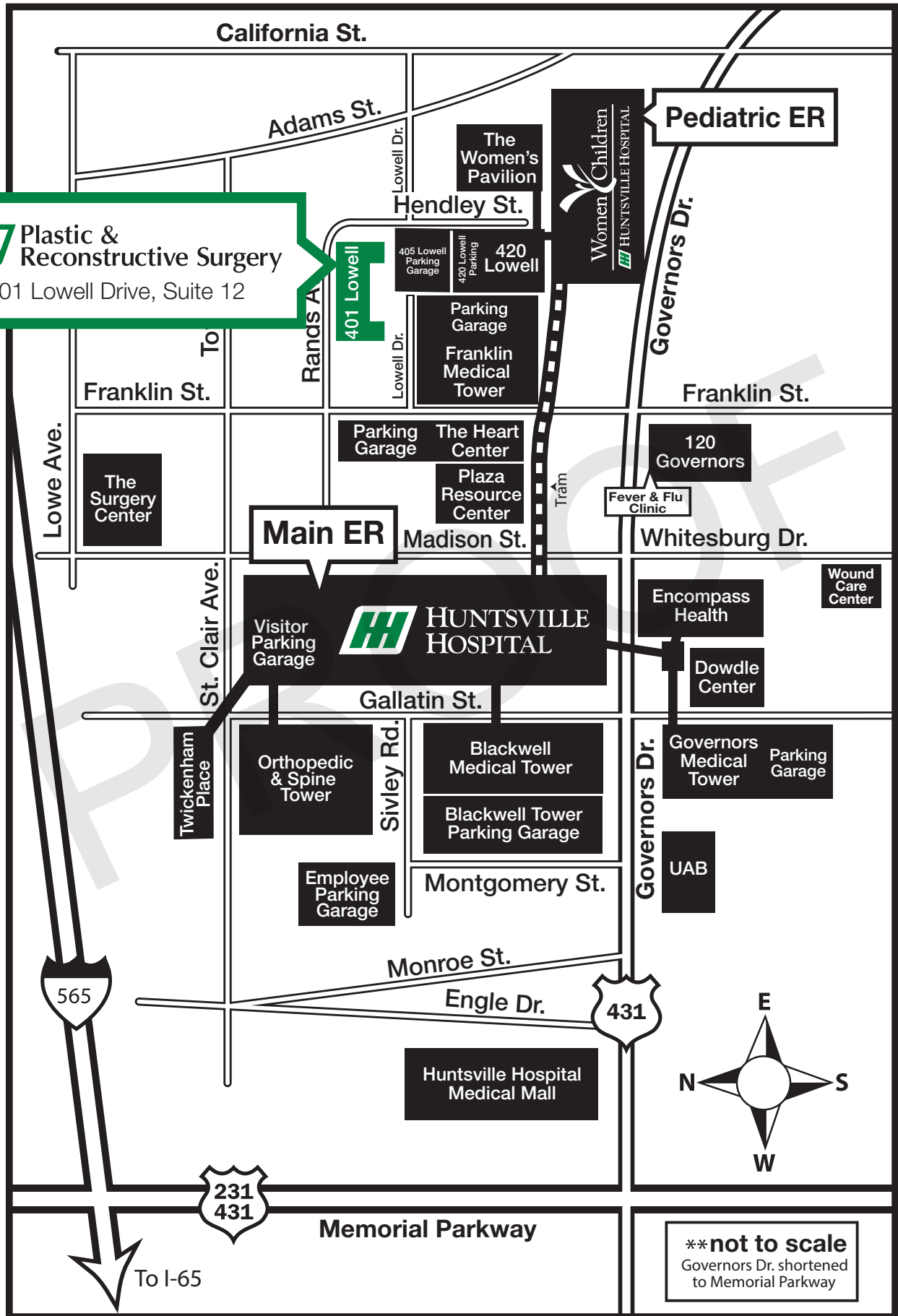
Relationship to patient (if signed by legal representative) _____

Signature of witness _____ Date _____ Time _____

OFFICE USE ONLY: Any portion of the record request found in paper chart? Yes No

HUNTSVILLE HOSPITAL / Medical District

 **Plastic & Reconstructive Surgery**
401 Lowell Drive, Suite 12



****not to scale**
Governors Dr. shortened
to Memorial Parkway