Plastic & Reconstructive Surgery

Abdelaziz Atwez, MD
Tony L. Weaver, DO, FACS

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.

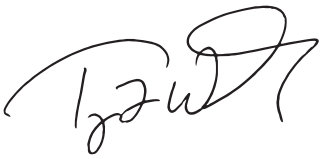
Our website *(hhplasticsurgery.org)* should help answer any questions you have about our office. We want you to know about our office services and what to expect at the time of your first visit.

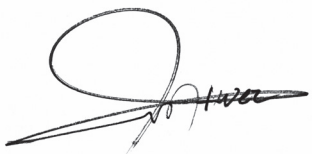
Please complete the enclosed forms prior to your appointment. Please bring them with you on your appointment date, along with your identification cards, insurance cards and medication list, as well as your co-payments and/or deductibles.

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, DO, FACS Abdelaziz Atwez, MD

Huntsville Hospital Plastic & Reconstructive Surgery

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

8337 Hwy 72 W Ste. 302
Madison, AL 35758
o: (256) 265-6851
f: (256) 817-6160

Plastic & Reconstructive Surgery

PATIENT INFORMATION

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

Plastic & Reconstructive Surgery

MEDICAL HISTORY WORK-UP SHEET

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.)*

- ☐ AIDS/HIV
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Anemia
- ☐ Anxiety
- ☐ Autoimmune Disease (Lupus)
- ☐ Biliary Cirrhosis
- ☐ Bipolar Disorder
- ☐ Blood Transfusion
- ☐ Brain Tumor
- ☐ Cirrhosis
- ☐ CVA/Stroke
- ☐ COPD (Lung Disease)
- ☐ Colon Cancer
- ☐ Coronary Heart Disease
- ☐ Crohn's Disease
- ☐ Chronic Kidney Disease
- ☐ Depression
- ☐ Diabetes - Type 1
- ☐ Diabetes - Type 2
- ☐ Diverticulitis
- ☐ DVT (Blood Clot in Legs)
- ☐ Eczema
- ☐ GI Bleed
- ☐ Gerd (Acid Reflux)
- ☐ Hemochromatosis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Goiter
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Infertility
- ☐ Insomnia
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ MI (Heart Attack)
- ☐ Migraine Headaches
- ☐ Neurological Disorder
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ PVD
- ☐ PUD (Stomach Ulcers)
- ☐ Radiation

_____# Treatments
_____ Dates

- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Thyroid Nodule
- ☐ Tuberculosis
- ☐ Valvular Heart Disease
- ☐ UTI - Recurrent
- ☐ Varicose Veins/Phlebitis
- ☐ Abnormal Pap Smear
- ☐ Breast Disease
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Gestational Diabetes
- ☐ Rh Sensitized
- ☐ Sleep Apnea

Using a CPAP? Yes / No

Other _____

PAST SURGICAL HISTORY

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

Other _____

Patient name: _____ DOB _____

BREAST IMPLANT/COSMETIC SURGERY HISTORY

Breast Implants Yes / No

If yes: ☐ Silicone
_____ date ☐ Saline

Current breast/bra size _____

Desired size and shape _____

Cosmetic Surgeries Yes / No

If yes please list procedure type and date

_____
Procedure Type Date

_____
Procedure Type Date

_____
Procedure Type Date

FAMILY HISTORY	Father	Mother	Brother	Sister	Children
High Blood Pressure	☐	☐	☐	☐	☐
Heart Artery Disease/Heart Attack	☐	☐	☐	☐	☐
Kidney Disease (Chronic)	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐
Cancer (Type)	☐	☐	☐	☐	☐

SOCIAL HISTORY *(Check or circle appropriate)*

☐ Married ☐ Single ☐ Divorced ☐ Widowed

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

Children: Yes / No Religious Affiliation _____

Number of pregnancies _____ Number of children _____ ☐ C-section ☐ Vaginal delivery

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 _____

Patient name: _____ DOB _____

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 _____

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
- ☐ Forgetfullness/ 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

Patient name: _____ DOB _____

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

	Date	**Results**	**Performed by (who/where)**
Colonoscopy	_____	_____	_____
Pap Smear	_____	_____	_____
Mammogram	_____	_____	_____
Bone Density Scan	_____	_____	_____
Menstural Period	_____	_____	_____
PSA (Prostate Sceen)	_____	_____	_____
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

HH System Clinics Registration Update Sheet

Patient: _____ Date of Birth: _____ Fin #_____

AUTHORIZATION TO CALL

I authorize HH System Clinics to leave the following messages on my answering machine/voicemail:

_____ Reminder appointments calls _____ Lab and/or Test results

HH SYSTEM CLINICS ADVANCE DIRECTIVE POLICY

In our practices we have decided that we will initiate resuscitative measures anytime they are needed.

FINANCIAL FEES AND ASSISTANCE

FINANCIAL FEES: I understand the following fee will be charged:

- A fee of $25 per form for completion of comprehensive forms. A fee will NOT be assessed for simple forms such as Work Excuse, School Excuse or application for Indigent Assistance for Medications. *Please allow a minimum of 7 days for completion of forms.*

FINANCIAL ASSISTANCE: I understand that financial assistance may be available for individual patients who are uninsured or who otherwise meet financial aid criteria. The hospital's overall ability to remain financially stable and provide essential health care services to all members of our community is dependent upon financial resources available to cover services provided to patients. My assistance in providing such information is necessary to determine possible financial aid available to me. If I am uninsured and need financial assistance, I may contact a Financial Counselor and make a request to see if I qualify at (256) 265-9438.

AUTHORIZATION OF TREATMENT

I hereby consent and authorize my physician and/or Allied Health professional to render usual and customary medical/emergency treatment that they deem advisable and necessary. I also authorize HH System Clinics to electronically request my medication history if my pharmacy participates in electronic prescribing in order to assist the provider in prescribing necessary medication therapy.

ASSIGNMENT OF BENEFITS, AGREEMENT AND GUARANTY

I authorize HH System Clinics to release any information regarding services rendered to me to third party payers in consideration of payment for my care or to other healthcare providers involved in my care. I understand payment of all insurance benefits, basic and major medical for this period of service must be made directly to HH System Clinics. If the check must be made out to me, I understand the check must be sent to this address: PN Billing P.O. Box 2705 Huntsville, AL 35804. I understand the HH System Clinics must collect for all charges not covered by insurance payments. Payment for all collection costs, securing, or attempting to collect and secure including reasonable attorney fees or Collection Agency fees, whether suit be necessary or otherwise is the financial responsibility of the patient and guardian. Patients who are considered a legal adult are financially responsible for all services rendered.

HH HEALTH SYSTEM NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that a copy of the Notice of Privacy Practices for HH Health System has been made available to me. In connection with the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents. I understand that the most current version of the Notice will be posted with the Health System and on *www.huntsvillehospital.org*.

EXPRESS PERMISSION TO CONTACT PATIENT BY CELL PHONE

I agree in order for HH System Clinic to service my account or to collect monies I owe, HH System Clinics and/or our agents may contact me by any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. HH System Clinics may also contact me by sending text messages or emails, using any email address I provided. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable. I have read this disclosure and agree that HH System Clinics, its employees, and/or agents may contact me as described.

Signature of Patient/Authorized Representative on behalf of patient: _____

Date: _____ Time: _____

Printed Name of Person Authorized to sign for patient: _____

Basis of Authority to sign for Patient: _____

---------- FOR USE BY HEALTH SYSTEM PERSONNEL ONLY ----------

--------(Complete if patient Acknowledgment is not obtained) ----------

The patient was provided with a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice. An Acknowledgment was not obtained because _____

Witness/Employee Signature: _____

Employee ID: _____

Date _____ Time _____

Plastic & Reconstructive Surgery

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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)
  - ☐ All/entire record
  - ☐ Visit/encounter notes
  - ☐ Laboratory results
  - ☐ X-ray and imaging reports
  - ☐ Problem list
  - ☐ Medication list
  - ☐ Allergies list
  - ☐ EKG report
  - ☐ Pathology report
  - ☐ Consultation report
  - ☐ Operative report
  - ☐ Immunization record
  - ☐ Drug and alcohol treatment
  - ☐ HIV/AIDS/STD treatment
  - ☐ Registration record
  - ☐ Other: _____

  Records release format:
  (choose one)
  - ☐ e-delivery (HealthPort connect)
  - ☐ CD
  - ☐ Paper
- 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

HH Plastic & Reconstructive Surgery

phone: (256) 265-6851 · fax: (256) 265-6869 Date: _____

AUTHORIZATION FOR PHOTOGRAPHY AND DISCLOSURE

Patient Information

Name: _____ Date of birth: _____

Photograph Authorization and Release Form

As a patient of HH Plastic & Reconstructive Surgery, I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery. The photos will be taken by an employee of The Health Care Authority of the City of Huntsville (HH Health System), which owns and operates HH PRS. I hereby give my authorization for HH Health System to use the photographs under one or more of the following circumstances:

Please initial all that apply

____**INTERNET:** Photographs taken of me or parts of my body as well as details regarding medical services that I received at HH Health System may be used only on HH Health Systems internet, website, and social media applications in order to inform the public about plastic surgery methods. Further, I release and discharge HH Health System; any of its employees; and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name or any other identifying marks at any time during any use or publication of these materials by any party.

____**ALL MEDIA:** Photographs taken of me or parts of my body as well as details regarding medical services that I received at HH Health System may be used only on HH Health Systems authorized print or broadcast media, including, but not limited to, HH Health Systems website, office photographic books, newspapers, pamphlets, brochures and educational material in order to inform the public about plastic surgery methods. Further, I release and discharge HH Health System; any of its employees; and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name or any other identifying marks at any time during any use or publication of these materials by any party.

____**MEDICAL CARE ONLY:** Photographs taken of me or parts of my body may be used solely for the purpose of my medical care with HH Health System. The photographs and all details regarding medical services rendered to me will be kept confidential within my medical record at HH Health System.

By signing this form, I acknowledge my authorization as initialed above, and I further recognize that this authorization form will supersede any other photograph authorization forms with a date prior to the date written below. I understand that I have the right to revoke this authorization at any time by written request or by completion of a new form; however, I understand that such revocation will not apply to photographs that have been previously released or disclosed in reliance upon this form. I also understand that my authorization is initialed above is voluntary, that I am not required to sign this form in order to receive any treatment, and that I may refuse to give such authorization without such refusal having any effect upon my treatment.

Signature: _____ Witness:_____