

Gregory J. Diehl, M.D., F.A.C.S.

Board Certified by the American Society of Plastic Surgeons



Name: _____
Last First Middle Initial

Date of Birth: ____/____/____

Age: _____

Address: _____

City State Zip

Marital Status: S M D W

Referred By: _____

SSN: _____

Family Dr: _____

Home Phone: _____

Emergency Contact Name: _____

Cell Phone: _____

Emergency Contact Phone: _____

Work Phone: _____ Ext: _____

Employer: _____

e-mail: _____

Patient's Occupation: _____

Okay to send mail/e-mails to above address? Yes ____ No ____

Okay to contact at above phone numbers? Yes ____ No ____

Responsible Party's Information

Name: _____

Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

SSN: _____

SSN: _____

Date of Birth: _____

Date of Birth: _____

Employer: _____

Employer: _____

For insurance cases only - Primary Insurance

For insurance cases only - Secondary Insurance

Insurance Name: _____

Insurance Name: _____

Policy Holder: _____

Policy Holder: _____

Policy Number: _____

Policy Number: _____

I HEREBY AUTHORIZE ANY PHYSICIAN, HEALTH CARE PRACTITIONER, HOSPITAL, MEDICALLY RELATED FACILITY, INS., CO., OR CONSUMER REPORTING AGENCY TO FURNISH ANY AND ALL RECORDS, PHOTOGRAPHS, MEDICAL HISTORY, SERVICES RENDERED OR TREATMENT GIVEN TO MYSELF OR ANY DEPENDENT FOR THE PURPOSE OF REVIEW, INVESTIGATION, OR EVALUATION ON ANY CLAIM SUBMITTED TO INSURER. I REQUEST THAT PAYMENT OF THE INSURANCE BENEFITS ON MY OPEN BALANCE BE PAID ON MY BEHALF TO GREGORY J. DIEHL, M.D., P.C., FOR THE SERVICES RENDERED BY THIS OFFICE.

SIGNATURE: _____ **DATE:** _____

Name: _____ Date: _____

Height: _____' _____" Weight: _____(lbs) Date Of Birth: _____/_____/____ Age: _____

Personal physician: _____ Phone: _____

What is the reason for today's visit? _____

Medical conditions for which you have been treated: _____

Surgeries you have had, with approximate dates: _____

Have you had Botox or facial fillers, such as Restylane, Juvederm or Radiesse? _____

YOUR PHAMACY'S Name: _____ Town: _____ Ph: _____

Current Medications: (include diet, herbal, natural, vitamins, aspirin, birth control and all over the counter medications)

Name: _____ Dosage: _____ To Treat: _____

Name: _____ Dosage: _____ To Treat: _____

Name: _____ Dosage: _____ To Treat: _____

Name: _____ Dosage: _____ To Treat: _____

Name: _____ Dosage: _____ To Treat: _____

Name: _____ Dosage: _____ To Treat: _____

Name: _____ Dosage: _____ To Treat: _____

Name: _____ Dosage: _____ To Treat: _____

Do you take daily aspirin or blood thinners?: _____ yes / no

Do you have allergies to any medication? _____

Describe reaction: _____

Have you ever smoked, if so how much? _____(cig / packs) per day and for how long? _____/years

Current tobacco use: _____(cig / packs) per day and for how long? _____/years

Note: this is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Have you had reactions to the following? Explain:

- Yes No Local Anesthetic (Lidocaine, Novacaine) _____
- Yes No Skin Disinfectant (Betadine) _____
- Yes No Corticosteroid Injection _____
- Yes No Adhesive Tape _____
- Yes No Pain Medication _____
- Yes No Antibiotics _____

Have you had or have the following conditions? Explain:

- Yes No Pulmonary (Lung) Condition _____
- Yes No Liver Disease/Hepatitis _____
- Yes No Kidney Disease _____
- Yes No Stomach Ulcers _____
- Yes No Diabetes _____
- Yes No Psychiatric Condition _____
- Yes No High Blood Pressure _____
- Yes No Heart Condition _____
- Yes No Heart Attack _____
- Yes No Stroke _____
- Yes No HIV/AIDS _____

Do or did you have a history of Bleeding Disorders (Hemophilia or von Willebrand Disease): _____yes / no_____

Do you take frequent anti-inflammatories or aspirin?: _____yes / no_____

Have you had the Flu Vaccine within the past year?: _____yes / no_____

Have you had the Pneumonia Vaccine within the past year?: _____yes / no_____

Do you have a risk of falling?: _____yes / no_____

FOR OFFICE USE ONLY: Blood Pressure _____

Signature: _____ Date: _____

Note: this is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

HIPAA PRIVACY NOTICE:

Patient: _____ Date: _____

I have read the patient's privacy information notice provided by Dr. Diehl's office and understand the rights I have under the law. I have no specific requirements.

[HIPAA Notice: provided upon request or available on website](#)

Signature of patient or guardian: _____

FOR MEDICARE PATIENTS ONLY:

Patient: _____ Date: _____

HEALTH INSURANCE CLAIMNUMBER: _____

I request that payment of authorized Medicare benefits be made on my behalf to Gregory J. Diehl for services provided to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits payable for related services.

Patient's signature: _____

INSURANCE PAYMENT AGREEMENT:

I, _____, agree to forward my insurance check, **un-cashed**, in full in original form, to Dr. Gregory Diehl.

Signature: _____ **Date:** _____

Susan: New patients forms

Legal Assignment of Benefits & Designation of Authorized Representative

I, the undersigned, represent that I have valid and in-force insurance and/or employee health care benefits coverage, and hereby assign and convey directly to, [entity name] and all medical professionals, including physician assistants of this practice, including, but not limited to [list the providers in your practice] Dr. Gregory J. Diehl, M.D. (the "provider(s)") as my Statutory Derivative Beneficiary (SDB), commonly known as a Designated Authorized Representative, and a Claimant under the "Patient Protection and Affordable Care Act" (PPACA), existing ERISA and other applicable federal and state laws., of all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the provider(s), regardless of the provider's 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 provider(s) to release all medical information necessary to process my claims under HIPAA.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the Designated Authorized Representative(s) any and all plan documents, including Governing Plan Documents, including, but not limited to a written explanation of how level of benefit payments are determined for out-of-network providers, Summary Plan Description, 5500 Form (Plan Annual Return), Certificate for PPACA Grandfathered Health Plan, where applicable, insurance policy and/or settlement information upon written request from the Designated Authorized Representative(s) in order to claim certain medical benefits in connection for healthcare services provided to the undersigned. This, includes, but is not limited to, receiving disbursement benefit checks for claims submitted, member's rights to appeal claim denials, as well as to claim any applicable statutory penalties on behalf of the plan participant and beneficiary. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the Designated Authorized Representative(s) to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, cause of action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but not limited to, (1) obtaining information about the claim to the same extent as the assignor, including, but not limited to, issuance of reimbursement checks, Explanation of Benefits and any/all correspondence related to claims reimbursement; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by the Designated Authorized Representative(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, to bring suit by the Designated Authorized Representative(s) against any such liable party or employee group health plan in my name with derivative standing but at such Designated Authorized Representative(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.

I have read and fully understand this agreement.

Signature of Insured / Guardian

Date

Print Name of Insured/Guardian