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

Board Certified by the American Society of Plastic Surgeons

DIEHL
PLASTIC SURGERY CENTER

Name: ______________________________
Last First Middle Initial

Date of Birth:______/______/______

Age: ______________________________

Address:
____

Marital Status: S __ M __ D __ W ______

____
City State Zip

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: ______________________________

Address: ______________________________
____

Phone: ______________________________

SSN: ______________________________

Date of Birth: ______________________________

Employer: ______________________________

Name: ______________________________

Address: ______________________________
____

Phone: ______________________________

SSN: ______________________________

Date of Birth: ______________________________

Employer: ______________________________

For insurance cases only - Primary Insurance

Insurance Name: ______________________________

Policy Holder: ______________________________

Policy Number: ______________________________

For insurance cases only – Secondary Insurance

Insurance Name: ______________________________

Policy Holder: ______________________________

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 of 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 Wilebrand Disease):_____yes / no_____

Do you take frequent anti-inflammatories or asprin?:______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 CLAIM NUMBER: ___________________________

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 an 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