

Plastic & Reconstructive Surgery of Annapolis

Kelly Sullivan, M.D.

888 Bestgate Road, Suite 208 Annapolis, MD 21401 Phone# 410-571-1280 / Fax# 410-571-1288

PATIENT MEDICAL HISTORY

CONFIDENTIAL INFORMATION: information contained herein will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information that you provide will be used by your doctor in decisions regarding your care.

Patient Information

Name: Last First Middle Date of Birth: Age:

Physician Information

Referring Physician: Address: Primary Care Physician: Address:

Medical Information

Reason for visit:

If this is for a medical reason, list date of onset:

Height: Weight:

Do you currently have, or have you ever had any of the following? (Please circle - if "yes", give date of onset/occurrence)

- AIDS or HIV+ No Yes Heart Condition No Yes
Anxiety No Yes Hepatitis No Yes
Arthritis No Yes High blood pressure No Yes
Asthma No Yes Kidney disease No Yes
Back problems No Yes Migraines No Yes
Bleeding disorder No Yes Seizure Disorder No Yes
Blood clotting disorder No Yes Stomach ulcers No Yes
Cancer No Yes Stroke No Yes
Colitis No Yes Thyroid disorder No Yes
Depression No Yes Tuberculosis No Yes
Diabetes No Yes Weight loss/gain No Yes
Heart attack No Yes

Other serious medical conditions that you have or have had, not mentioned above:

Have you ever had surgery? (If "yes", please list the name of the operation and the date it was performed):

Other serious illnesses or injuries that you have had, not mentioned above:

Have you ever had any complications from anesthesia? (If "yes", please explain):

**Social History**

Do you currently smoke?  Yes  No

If "yes": What? \_\_\_\_\_ How Much? \_\_\_\_\_  
and for How long? \_\_\_\_\_

If "no": **Have you ever smoked?**  Yes  No

If "yes": When did you quit? \_\_\_\_\_

Do you have any known allergies to medications, iodine/contrast dye, or LATEX? \_\_\_\_\_

If "yes", please list: \_\_\_\_\_  No  Yes

Do you regularly drink alcohol?  Yes  No

If "yes": How much? \_\_\_\_\_  
How often? \_\_\_\_\_

**For women only:**

Is there a chance you might be pregnant?  No  Yes

Are you still having regular monthly menstrual periods?  No  Yes

No  Yes

Date of last period? \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_ Results: \_\_\_\_\_

How many children do you have? \_\_\_\_\_

*We recommend routine breast and pelvic exams by your physician for all adult females.*

Are you presently taking any of the following medications? (If "yes", please circle and list the name of the medication).

Accutane (Isotretinoin) \_\_\_\_\_

Herbal Supplement \_\_\_\_\_

Antibiotics \_\_\_\_\_

Hormones \_\_\_\_\_

Anxiety/Depression Meds \_\_\_\_\_

Insulin or diabetic pills \_\_\_\_\_

Arthritis medicine \_\_\_\_\_

Laxatives \_\_\_\_\_

Aspirin, Bufferin, Anacin \_\_\_\_\_

Retin-A \_\_\_\_\_

Birth control pills \_\_\_\_\_

Seizure Meds \_\_\_\_\_

Blood pressure pills \_\_\_\_\_

Sleeping pills \_\_\_\_\_

Blood thinning pills \_\_\_\_\_

Steroids \_\_\_\_\_

Cough medicine \_\_\_\_\_

St. Johns Wart \_\_\_\_\_

Digitalis \_\_\_\_\_

Thyroid medicine \_\_\_\_\_

Headache meds \_\_\_\_\_

Water pills \_\_\_\_\_

Weight reducing pills \_\_\_\_\_

Other vitamins, supplements, or medications not listed above: \_\_\_\_\_

**Family Medical History**

If a blood relative has/had any of the following conditions, please circle and give relationship (blood relatives includes siblings, parents, grandparents, children):

Bleeding tendency \_\_\_\_\_

Heart disease \_\_\_\_\_

Blood clotting disorder \_\_\_\_\_

Diabetes \_\_\_\_\_

Breast cancer \_\_\_\_\_

Stroke \_\_\_\_\_

Please list anything about yourself or your health that you think would be important for the doctor to know: \_\_\_\_\_



# PATIENT REGISTRATION FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Street # City State Zip

Sex:  Female  Male Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home No.: \_\_\_\_\_ Cell No.: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Employer: \_\_\_\_\_ Work No.: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**\* If patient is a minor:** Name of person financially responsible: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Referred By: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

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**Insurance Carrier (PRIMARY):** \_\_\_\_\_

Group #: \_\_\_\_\_ Member/ID #: \_\_\_\_\_ Employer: \_\_\_\_\_

Specialist Co-pay amount: \_\_\_\_\_ Date Effective: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex:  Female  Male Relationship: \_\_\_\_\_

**Secondary Insurance Carrier:** \_\_\_\_\_

Group #: \_\_\_\_\_ Member/ID #: \_\_\_\_\_ Employer: \_\_\_\_\_

Specialist Co-pay amount: \_\_\_\_\_ Date Effective: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex:  Female  Male Relationship: \_\_\_\_\_

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\_\_\_\_\_ \* I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits directly to the physician or supplier of services for myself and/or dependents. I understand I am responsible for any deductibles, co-pays, or coinsurances. \*I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan. \*I authorize my provider's office to contact me by telephone to remind me of my appointments.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date



Dr. Kelly Sullivan

**Patient Photograph Release Form**

**Patient Information**

Patient's Name: \_\_\_\_\_  
Last First Middle

Patient's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Photograph Consent and Release**

*(Please initial)* \_\_\_\_\_ 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 photographs will be taken by one of the members of the Plastic & Reconstructive Surgery of Annapolis medical staff. Any photographs taken will become part of my medical records. I hereby give my consent for Plastic & Reconstructive Surgery of Annapolis to use the photographs under the following conditions:

*(Please initial)* \_\_\_\_\_ I authorize my photographs to be used for the purposes of insurance pre-authorization, office and hospital medical charts, and any necessary medical treatment.

*(Please initial)* \_\_\_\_\_ I authorize my photographs to be used for the purposes of: Medical Seminars, website publication and/or office photo albums. All efforts will be made to ensure patient anonymity and confidentiality. No names or identifying references will be made in conjunction with published photography.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness's Signature: \_\_\_\_\_

**The American Board of Plastic Surgery, Inc. Submission Consent**

*(Please initial)* \_\_\_\_\_ I hereby grant permission for the use of any of my medical records, illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

Please note, the Board requires that all identifiable characteristics, with the exception of a full face photograph or photograph of a uniquely identifiable characteristic, be blanked out for submission of materials for the Oral Examination of The American Board of Plastic Surgery to protect patient privacy.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness's Signature: \_\_\_\_\_



## Notification of Insurance Policy and Procedure

In an effort to better serve our patients, PRSOA is no longer participating with certain insurance carriers but will continue to help you, our patients, negotiate with your individual insurance plans in order to obtain the benefits allowed by your particular plan. Please review the policies as listed below and mark the section that describes your situation so that we may further assist you with the insurance billing process.

- I am a member of a PPO or dual coverage plan with which PRSOA does not participate. I understand that I must have Out-of-Network benefits for a consultation, appointment or procedure with Dr. Kelly Sullivan. PRSOA will submit all claims on my behalf. I am responsible for payment of the consultation fee (ranging from \$100 - \$200) in full at the time of service and I will receive reimbursement from my insurance company. I will be responsible for paying all co-pays and deductibles at the time of service for an office based procedure; and at the pre-op visit (1 – 2 weeks prior to surgery) for any operating room based procedures.

Any Explanation of Benefits (E.O.B.'s) and/or payment made directly to me by my insurance company must be turned over to Plastic & Reconstructive Surgery of Annapolis **within five business days** of receipt. If I fail to forward any payment from my insurance company to PRSOA, or if the bill remains unpaid 45 days after service is rendered, all unpaid claims will be billed directly to me.

- I am a member of an HMO with which PRSOA does not participate. Plastic & Reconstructive Surgery of Annapolis does not participate with my plan, and therefore the services will not be covered by my insurance. I understand that there are other reconstructive surgeons who are “in network” with my insurance plan, but I have decided that I want Dr. Kelly Sullivan to provide the medical/surgical treatment for me, and I will be solely responsible for paying my medical bill.
- I am on Medical Assistance/MCO and knowingly choose to be seen. I understand the electronic verification system and/or my assigned MCO tells me that this is an unauthorized visit/procedure and is not covered. I will be solely responsible for payment of my entire medical bill.
- I am a policyholder of either Informed or Medicare insurance companies. I authorize PRSOA to submit claims on my behalf. I will be responsible for all co-pays and deductibles at the time of service.
- I am receiving services for cosmetic reasons and understand that I am personally responsible for payment of any services that will be rendered. My insurance company will not be involved in the billing process.

I completely understand Plastic & Reconstructive Surgery of Annapolis' insurance policy and procedure and agree to these terms.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_

Updated 3/18/10