

PAUL L. PROFFER, M.D.
1611 Wallace Blvd.
AMARILLO, TX 79106
(806) 354-4900

Patient's Full Name: _____ Name Preferred to be Called: _____ Sex: _____
Street Address: _____ Race: _____
City: _____ State: _____ Zip: _____ Home Ph: (____) _____ Cell Ph: (____) _____
Birth Date: _____ Age: _____ Social Security No: _____
E-Mail Address: _____
Marital Status: (circle) M S W D Spouse's Name: _____
Spouse's Social Security No: _____ Spouse's Birth Date: _____

Responsible Party (if different than patient or spouse): _____
Address: _____ City/State/Zip: _____
Social Security No: _____ Birth Date: _____ Relationship to patient: _____
Responsible Party Home Ph: (____) _____ Cell Ph: (____) _____

If Referred by Another Physician – Physician Name: _____
Address: _____ City/State/Zip: _____
Phone: (____) _____
Primary Care Physician (if different from referring Physician): _____
Address: _____ City/State/Zip: _____ Phone # _____

Primary Insurance Company

Name: _____
Address: _____
City/State/Zip: _____
ID Number: _____
Subscriber: _____
Subscriber Social Security No: _____
Subscriber DOB: _____

Secondary Insurance Company

Name: _____
Address: _____
City/State/Zip: _____
ID Number: _____
Subscriber: _____
Subscriber Social Security No: _____
Subscriber DOB: _____

Patient's Employer (or retired from): _____
Address: _____ City/State/Zip: _____
Work Ph: (____) _____

Spouse's (or Responsible Party's) Employer (or retired from): _____
Address: _____ City/State/Zip: _____
Work Ph: (____) _____

Emergency Contact: _____ Relationship: _____
Address: _____ City/State/Zip: _____
Phone: (____) _____ Cell Ph: (____) _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION BY PROFFER SURGICAL ASSOCIATES, LLP FOR ANY INSURANCE CLAIMS SUBMISSION AND AT THE DOCTOR'S DISCRETION, ASSIGN THE INSURANCE PAYMENT TO THEM FOR THESE SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES THAT ARE NOT COVERED.

DATE OF INJURY: _____ REASON FOR VISIT: _____
PREFERRED PHARMACY _____
PHONE: _____

PATIENT OR RESPONSIBLE PARTY
SIGNATURE: _____

DATE: _____

Today's Date: _____

Proposed Procedure: _____

Reviewed By: _____

Allergies (Food & Drugs)

Height: _____

Weight: _____

Previous Surgical History (Including Eye Surgeries & Eyelid Surgery)

Family History:

CHECK ALL THAT APPLY TO YOU NOW OR IN THE PAST

CARDIOVASCULAR	RESPIRATORY	GASTROINTESTINAL
<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Heart Attack _____ Year <input type="checkbox"/> Angina / Chest Pain <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Coronary Artery Bypass Grafts <input type="checkbox"/> Angioplasty / Stents _____ Year <input type="checkbox"/> Irregular Heart Beat / Arrhythmia <input type="checkbox"/> Heart Murmur / Valve Prolapse <input type="checkbox"/> Pacemaker / ICD <input type="checkbox"/> Difficulty Walking Up Stairs <input type="checkbox"/> Cardiologist _____ <input type="checkbox"/> DVT (Blood Clots in Legs)	<input type="checkbox"/> Cough / Cold Last 2 Weeks <input type="checkbox"/> Asthma / Wheezing <input type="checkbox"/> Emphysema / COPD <input type="checkbox"/> Bronchitis <input type="checkbox"/> Sleep Apnea _____ CPAP Used <input type="checkbox"/> TB <input type="checkbox"/> Allergies / Sinus <input type="checkbox"/> Other Lung Disease <input type="checkbox"/> Blood Clots In Lungs	<input type="checkbox"/> Ulcer <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Frequent Heart Burn <input type="checkbox"/> Acid Reflux <input type="checkbox"/> Other GI Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Other Liver Disease
	ENDOCRINE	BLOOD
	<input type="checkbox"/> Diabetes – Yr Dx. _____ <input type="checkbox"/> Insulin: _____ <input type="checkbox"/> Oral Meds <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Other Endocrine Disease <input type="checkbox"/> Steroid Medication In Past Year	<input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Hemophilia <input type="checkbox"/> Other Blood Disease <input type="checkbox"/> AIDS / HIV <input type="checkbox"/> Do You Take Aspirin Daily <input type="checkbox"/> Name Blood Thinners taken Daily _____
NEUROLOGIC		OTHER
<input type="checkbox"/> Anxiety / Depression <input type="checkbox"/> Mental Disorders <input type="checkbox"/> Epilepsy / Seizures <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Stroke / Paralysis <input type="checkbox"/> Polio <input type="checkbox"/> Migraines <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Spinal Cord Abnormality <input type="checkbox"/> Other Neuro Disease	SOCIAL	<input type="checkbox"/> Malignant Hyperthermia <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Rheumatoid Arthritis / Lupus <input type="checkbox"/> Enlarged Prostate <input type="checkbox"/> TMJ <input type="checkbox"/> Cancer <input type="checkbox"/> Loose / Missing Teeth <input type="checkbox"/> Capped Teeth <input type="checkbox"/> Dentures / Partial <input type="checkbox"/> Recent Dental Work <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Glaucoma <input type="checkbox"/> MRSA _____ Latex Allergy <input type="checkbox"/> *Other _____
KIDNEY	<input type="checkbox"/> Tobacco Use <input type="checkbox"/> Have you EVER Smoked Yes No <input type="checkbox"/> Packs Per Day for _____ Years <input type="checkbox"/> Quit _____ Years Ago <input type="checkbox"/> Alcohol _____ Yes _____ No Amount _____ Have You Ever Used Street Drugs? <input type="checkbox"/> Yes _____ No <input type="checkbox"/> Regular Exercise Program	
SKIN CANCER HISTORY	VACCINATIONS	
<input type="checkbox"/> Basal Cell Carcinoma <input type="checkbox"/> Squamous Cell Carcinoma <input type="checkbox"/> Melanoma <input type="checkbox"/> Other <input type="checkbox"/> Have You Ever Been Treated with Mohs Surgery? _____	<input type="checkbox"/> Flu <input type="checkbox"/> Pneumonia Date of Injections _____	Patient / Guardian Signature X _____

Patient Sticker

Patient Name: _____

Patient Sticker

Please list ALL drug **ALLERGIES** and reactions

Medication	Reaction

Please list ALL medications, vitamins and over-the counter medications taken:

Medication	Dosage	Frequency Taken	Why Medication is Taken	Last Taken	FOR PHYSICIAN USE ONLY		
					Discharge Order		
					Continue	Stop	Change

Continue on Back if Needed

Physician/Licensed Independent Practitioner _____ Date & Time _____

Patient/Other Signature _____ Date & Time _____

Discharge Staff Signature _____ Date & Time _____

Proffer Surgical Associates

ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgment.

I _____ have received a copy of this office's Notice of Privacy Practices. *You have the right to refuse to sign this document*

(Please Print Name)

(Signature)

Date: _____

I give permission to release medical information to the following persons:

Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____

Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

_____ The patient or individual refused to sign this document

_____ Communications conflicts prohibited us from obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please specify) _____

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, the undersigned patient consent to the following, photographs and/or videos of me to be used by Proffer Surgical Associates.

I consent to such photographs, videos and any associated quotes by me being edited and published by my Doctor and/or any party acting under my Doctor's license and authority in any print or electronic form, including, but not limited to posts on social media, for the purpose of informing the medical profession or the general public about aesthetic procedure methods and results, surgical and non-surgical, and whether or not such settings are regarded as educational, scientific or commercial.

I expect to be recognized from my likeness or quotes.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will exist in perpetuity from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from my Doctor.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I release and discharge my Doctor and all parties acting under my Doctor's license and authority from all rights that I may have in the photographs, videos or quotes and from my claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these material in any medium. I certify that I have read the above Authorization and Release and fully understand its terms.

Patient Signature

Witness / Physician

Printed Patient Name

Date

I have read the above Authorization and Release. I am the parent, guardian or conservator of the patient, a minor. I am authorized to sign this consent on the patient's behalf.

Patient/Guardian/Conservator Signature

Date

Printed Patient/Guardian/Conservator Name



Marketing Authorization Form

Patient Name: _____ Date: _____

1. Authorizing marketing communication from this practice means I may:
 - a. Receive treatment communications concerning treatment alternatives or other health related products or services.
 - b. Be contacted for appointment reminders or information about treatment alternatives or other health related benefits and services that may interest me.
- **I understand that I have the right to "opt out" of receiving such communications.**
- **I understand that this practice may receive remuneration for communications.**

Other communications for such purposes that do not involve financial remuneration are adequately captured in this practice's notice of privacy practices (NPP).

2. Marketing Authorization Options:

- I wish to receive Marketing Communications from this Practice Only.**
- I wish to receive Marketing Communications from this Practice, and this Practice's Business Associates.**
- I do NOT wish to receive any Marketing Communications.**

Patient Signature: _____

Communication that encourages you to use our services is considered marketing. If we intend to use, or sell PHI for personal gain or commercial advantage, we must **first obtain written authorization**. Authorization is required for all treatment and health care operations communications where the covered entity receives financial remuneration for making the communications for a third party whose product or service is being marketed. Such a policy will ensure that all such communications are treated as marketing communications, instead of requiring covered entities to have two processes in place based on whether the communication provided to individuals is for a treatment or a health care operations purpose. **We MAY receive financial remuneration from a third party due to marketing.**

HIPAA states the term "financial remuneration" does not include non-financial benefits, such as in-kind benefits, provided to a covered entity in exchange for making a communication about a product or service. Rather, financial remuneration includes only payments made in exchange for making such communications.

In addition, HIPAA emphasizes that the financial remuneration a covered entity receives from a third party must be for the purpose of making a communication and such communication must encourage individuals to purchase or use the third party's product or service. If the financial remuneration received by the covered entity is for any purpose other than for making the communication, then this marketing provision does not apply.