Patrick H. Pownell, M.D., P.A.
PLASTIC AND RECONSTRUCTIVE SURGERY

REGISTRATION INFORMATION

Date: _____

Name: _____
(First) (MI) (Last)

Home Address: _____
(Street) (City/State) (ZIP)

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Date of Birth: _____ Age: _____ Male ( ) Female ( )

Social Security #: _____ Driver's License #: _____

Marital Status: _____

Spouse's Full Name: _____ Spouse's Date of Birth: _____

Is there someone we may thank for this referral? _____

Their Address: _____
□ Friend □ Doctor □ Former Patient □ Other _____
Can we thank this referral in writing? □ Yes □ No

Patient's Employer: _____

Employer's Address: _____

Occupation: _____ Time Employed: _____

Name and Relation of Nearest Contact: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Person Responsible for Bill: □ Self □ Other (Please complete below if other than patient)

Name: _____ Date of Birth: _____

Address: _____

Employer: _____ Occupation: _____ Time Employed: _____

Relationship to Patient: _____ Social Security #: _____ Driver's License #: _____

Home Phone #: _____ Work Phone: _____

Cell Phone: _____

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HEALTH INFORMATION

Patient Name: _____ Date:_____

Purpose of appointment with Dr. Pownell:_____

Medical History

Do you now have or have you ever had any of the following:

	YES	NO		YES	NO		YES	NO
Rheumatic Fever	☐	☐	Shortness of Breath	☐	☐	Eye Diseases	☐	☐
Heart Murmurs	☐	☐	High Blood Pressure	☐	☐	Thyroid Problems	☐	☐
Heart Palpitations	☐	☐	Diabetes	☐	☐	Asthma	☐	☐
Irregular Heart Beat	☐	☐	Cancer	☐	☐	Anemia	☐	☐
Chest Pains	☐	☐	Kidney Problems	☐	☐	Blood Disorders	☐	☐
Clinical Depression	☐	☐	Psychiatric Disorder	☐	☐			
Any Other Serious Illness	☐	☐				Chronic lung or bronchial disease	☐	☐
						Trouble with dryness, soreness, burning, itching or excessive tearing of eyes	☐	☐

Hospitalizations and/or previous surgeries: Please list with dates:_____

_____

Allergies

Are you allergic to, or have you ever had a reaction to any medication, drug or local anesthetic? Yes ☐ No ☐

If Yes, please list:

_____

Medications

Please list any medication you currently take on a regular basis (aspirin, ibuprofen, birth control pills, herbals, and vitamins included).

_____

Please list any medications taken on a regular basis in the past five (5) years.

_____

Bleeding/Scarring/Anesthesia

	YES	*NO*
Do you or a member of your family have difficulty with prolonged bleeding when cut?	☐	☐
Do you or a member of your family bruise easily?	☐	☐
Do you have a problem with excessive scarring or have you ever formed a keloid after being cut?	☐	☐
Have you or any member of your family ever had a problem with anesthesia?	☐	☐

If yes to any of the above, please explain:_____

Personal History

How would you describe your general health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Do you smoke? Yes ☐ No ☐ _____/per day Have you smoked in the last 5 years? Yes ☐ No ☐

Do any diseases run in your family? _____

Date of last physical examination? _____

Primary Care Physician: _____

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MEDICAL INSURANCE INFORMATION

Patients should sign in both signature blanks at the bottom of this page.

PRIMARY INSURANCE

Name of Primary Insurance Company: _____

Address and Phone Number of this Company: _____

_____

Name of Insured: _____

Address (if different from patient): _____

Insured's Employer: _____

Insured's SSN: _____ Insured's Date of Birth: _____

Group/Policy #: _____ ID#: _____

SECONDARY INSURANCE

Do you have additional Insurance coverage? _____ Yes _____ No

Name of Secondary Insurance Company: _____

Address and Phone Number of this Company: _____

_____

Name of Insured: _____

Insured's Employer: _____

Insured's SSN: _____ ID#: _____

Group/Policy#: _____ ID#: _____

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the undersigned physician or supplier for services described.

_____
Signed (Insured/Authorized Person) Date

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process claims and/or predetermination letters.

_____
Signed (Patient, or parent if minor) Date

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In the course of treatment with Dr. Pownell, you may be referred to, or certain surgical services may be performed at, Texas Institute for Surgery at Presbyterian Hospital of Dallas. Dr. Pownell has an ownership interest in this hospital, and as a result, he may financially benefit from the referral of services to the hospital in the form of increased dividends or distributions. You have the option of using an alternative health care facility. *Please let us know if you have any concern regarding the financial relationship between Dr. Pownell and Texas Institute for Surgery at Presbyterian Hospital of Dallas.*

Acknowledgement of Review of "Notice of Privacy Practices Form"

I have reviewed the Notice of Privacy Practices for this office which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

E-Mail Policy

To better serve our patients, this office has established an e-mail address for some forms of communication.

Forms of communication that are appropriate include:

Scheduling Inquiries
Insurance Questions
Educational Materials

Please note, any and all healthcare questions should be addressed via phone communication Or physician visit.

_____
Signature of Patient or Personal Representative

_____Date