

REGISTRATION FORM
(Please Print)

PATIENT INFORMATION

Last Name:		First Name:		Middle Name:	Sex:	Marital status (circle one)	
					<input type="checkbox"/> Male <input type="checkbox"/> Female	Single / Mar / Div / Sep / Wid	
Social Security Number:	Date of Birth:		Age:	Place of Birth:			
	/ /			City:		State:	
Street Address:				Email Address:			
City:					State:	ZIP Code:	
Home Phone Number:		Cell Phone Number:		Preferred Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell			
()		()		Is it ok to leave a detailed message? <input type="checkbox"/> NO <input type="checkbox"/> YES			
Language:	Race:		Ethnic Group:		Would you like access to the patient portal to access your medical information online?		
<input type="checkbox"/> English <input type="checkbox"/> _____	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White		<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		<input type="checkbox"/> Yes <input type="checkbox"/> No		

EMERGENCY CONTACT INFORMATION

Name:	Relationship:	Phone:
		()
		()

EMPLOYMENT INFORMATION

Occupation:	Employer:	Employer Phone:	
		()	
Employer Address:	Employer City:	Employer State:	Employer Zip:

PHARMACY INFORMATION

Pharmacy Name:	Pharmacy Address:	Pharmacy Phone Number:

PHYSICIAN INFORMATION

Referring Physician:
Primary Care Physician:

Reason for Visit

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HEALTH INFORMATION

Please tell us if you have any problems related to the following body systems. Check "No Problems" at the top of each category if you have systems related to that body system. Check any specific problems that you have.

<p>Constitutional <input type="checkbox"/>No Problems</p> <p><input type="checkbox"/> fever <input type="checkbox"/> weight gain <input type="checkbox"/> chills <input type="checkbox"/> weight loss <input type="checkbox"/> night sweats <input type="checkbox"/> exercise intolerance <input type="checkbox"/> change in appetite <input type="checkbox"/> Other _____</p>	<p>Musculoskeletal <input type="checkbox"/>No Problems</p> <p><input type="checkbox"/> muscle aches <input type="checkbox"/> back pain <input type="checkbox"/> muscle cramps <input type="checkbox"/> problems walking <input type="checkbox"/> joint pain <input type="checkbox"/> foot drop <input type="checkbox"/> joint swelling <input type="checkbox"/> Other _____ <input type="checkbox"/> muscle weakness</p>
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<p>Eyes <input type="checkbox"/>No Problems</p> <p><input type="checkbox"/> dry eyes <input type="checkbox"/> floaters <input type="checkbox"/> irritation <input type="checkbox"/> sensitivity to light <input type="checkbox"/> pain <input type="checkbox"/> double vision <input type="checkbox"/> visual change <input type="checkbox"/> discharge <input type="checkbox"/> Other _____</p>	<p>Skin <input type="checkbox"/>No Problems</p> <p><input type="checkbox"/> dry skin abnormal <input type="checkbox"/> excessive sweating <input type="checkbox"/> moles breast <input type="checkbox"/> itching <input type="checkbox"/> discharge breast <input type="checkbox"/> rash <input type="checkbox"/> lump or pain <input type="checkbox"/> change in skin color <input type="checkbox"/> wound healing problems <input type="checkbox"/> bleeding or ulcerated lesions <input type="checkbox"/> Other _____</p>
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<p>Eyes, Nose, Throat <input type="checkbox"/>No Problems</p> <p><input type="checkbox"/> difficulty hearing <input type="checkbox"/> vertigo <input type="checkbox"/> ear pain <input type="checkbox"/> ringing in ears <input type="checkbox"/> vertigo <input type="checkbox"/> frequent nosebleeds <input type="checkbox"/> ringing in ears <input type="checkbox"/> sinus problems <input type="checkbox"/> frequent nosebleeds <input type="checkbox"/> neck pain/tender <input type="checkbox"/> sinus problems <input type="checkbox"/> teeth problems <input type="checkbox"/> difficulty hearing <input type="checkbox"/> Other _____ <input type="checkbox"/> ear pain</p>	<p>Neurologic <input type="checkbox"/>No Problems</p> <p><input type="checkbox"/> loss of consciousness <input type="checkbox"/> tingling <input type="checkbox"/> slurred speech <input type="checkbox"/> tremor <input type="checkbox"/> weakness <input type="checkbox"/> seizures <input type="checkbox"/> numbness <input type="checkbox"/> dizziness <input type="checkbox"/> headache <input type="checkbox"/> memory problems <input type="checkbox"/> restless legs <input type="checkbox"/> loss of balance <input type="checkbox"/> Other _____</p>
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<p>Cardiovascular <input type="checkbox"/>No Problems</p> <p><input type="checkbox"/> chest pain <input type="checkbox"/> heart murmur <input type="checkbox"/> arm pain w/exercise <input type="checkbox"/> lightheadedness <input type="checkbox"/> shortness of breath <input type="checkbox"/> ankle/leg swelling <input type="checkbox"/> irregular heartbeat <input type="checkbox"/> Other _____</p>	<p>Psychiatric <input type="checkbox"/>No Problems</p> <p><input type="checkbox"/> irritability <input type="checkbox"/> paranoid thoughts <input type="checkbox"/> depression <input type="checkbox"/> suicidal thoughts <input type="checkbox"/> anxiety <input type="checkbox"/> hallucinations <input type="checkbox"/> panic attacks <input type="checkbox"/> psychotic episode <input type="checkbox"/> sleep problems <input type="checkbox"/> Other _____</p>
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<p>Respiratory <input type="checkbox"/>No Problems</p> <p><input type="checkbox"/> wheezing <input type="checkbox"/> frequent cough <input type="checkbox"/> shortness of breath <input type="checkbox"/> sleep apnea <input type="checkbox"/> rapid breathing <input type="checkbox"/> Other _____ <input type="checkbox"/> problem snoring</p>	<p>Endocrine <input type="checkbox"/>No Problems</p> <p><input type="checkbox"/> fatigue <input type="checkbox"/> abnormal hair growth <input type="checkbox"/> cold or heat intolerance <input type="checkbox"/> hair loss <input type="checkbox"/> decreased sex drive <input type="checkbox"/> irregular periods <input type="checkbox"/> erection problems <input type="checkbox"/> abnormal menses <input type="checkbox"/> Other _____</p>
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<p>Gastrointestinal <input type="checkbox"/>No Problems</p> <p><input type="checkbox"/> nausea <input type="checkbox"/> loss of appetite <input type="checkbox"/> vomiting <input type="checkbox"/> diarrhea <input type="checkbox"/> vomiting blood <input type="checkbox"/> constipation <input type="checkbox"/> abdominal pain <input type="checkbox"/> heartburn <input type="checkbox"/> blood in stools <input type="checkbox"/> Other _____</p>	<p>Blood & Lymphatic <input type="checkbox"/>No Problems</p> <p><input type="checkbox"/> swollen glands <input type="checkbox"/> easy bruising <input type="checkbox"/> blood clots <input type="checkbox"/> bleeding problems <input type="checkbox"/> Other _____</p>
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<p>Genitourinary <input type="checkbox"/>No Problems</p> <p><input type="checkbox"/> pain w/urination <input type="checkbox"/> urge to urinate <input type="checkbox"/> loss of bladder control <input type="checkbox"/> flank pain <input type="checkbox"/> difficulty urinating <input type="checkbox"/> frequent infections <input type="checkbox"/> frequent urination <input type="checkbox"/> Other _____</p>	<p>Allergy & Immune <input type="checkbox"/>No Problems</p> <p><input type="checkbox"/> nasal allergies <input type="checkbox"/> hives <input type="checkbox"/> frequent infections <input type="checkbox"/> immune compromised <input type="checkbox"/> Other _____</p>
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Please List Any Prior Surgeries:

Surgery:	Date:	Doctor:	Hospital:

Please list all current medications (include over-the-counter medications):

Medicine:	Dose:	Frequency:	Medicine:	Dose:	Frequency:

Allergies:

Name:	Reaction:	Name:	Reaction:

Please indicate any health problems which any of your blood relatives have or had:

Health Condition / Disease:	Relative:

Are you pregnant? NO YES **If Yes, When is your due date?** / /

SOCIAL HISTORY

Do you smoke or use tobacco? NO YES If YES, type Cigarettes Cigars Pipe Chewing or Smokeless Tobacco Other
 If YES, frequency of use:

Do you use other nicotine products (i.e. E-cig, Nicorette gum/lozenge, Nicotine patch, Nicotrol inhaler)? NO YES

Do you drink alcohol? NO YES If YES, number of drinks per day week month

Type of alcohol consumed Beer Wine Liquor Other

Do you have a history of substance abuse? NO YES Does anyone in your household have a history of substance abuse? NO YES

Amphetamines Cocaine Marijuana Methamphetamines Prescription medications / Name _____
 Inhalants Heroin Hallucinogens/LSD Other

Lives with: Alone Children Father Mother Parents Siblings Significant Other Spouse Other _____

Diet Type: Regular Soft Calorie Controlled Vegetarian Other _____

Are there Cultural/Spiritual practices that we should be aware of? No Yes

Please explain:

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copay is due at the time of service.
 I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provides is factual and correct.

Patient or Guardian Signature	Date
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HIPAA Disclosure Form

Last Name:	First Name:	Middle Name:	Date of Birth:

Privacy & Confidentiality Notice Acknowledgement (Reference Federal Register 45 C.F.R. §164.506)

I understand that protected health information may be used and disclosed to perform treatment, payment and/or health care operations. I acknowledge I've been given the opportunity to read, review, and obtain a complete copy of The Myers Institute of Plastic and Hand Surgery Notice with a complete description of such uses and understand I had a right to review the privacy notice before signing below. I understand I have a right to request this office to restrict how my information is used, but this office may not agree with the requested restrictions. I have a right to revoke this authorization and consent, in writing, at any time. This office reserves the right to amend the privacy policy, whether required by law or otherwise, and a revised notice may be obtained by calling our office or physically coming to our office.

Designated Party Authorization for Release of Medical Information (Optional)

Some patients prefer that other individuals, especially family members, be allowed access to their medical information. In order to comply with strict legal standards, a written release is required to allow another person access to your medical records. This release grants permission to individual(s) listed below to: Make or confirm appointments, have access to x-ray and laboratory findings, pick up sample medications, be made aware of your diagnosis, prognosis, and treatment plans, and serve as your emergency contact. This permission applies to telephone and answering machine messages as well as other means of communication and will be in effect unless I notify this office of any changes or revocations.

Name:	Relationship:	Phone Number:
		()
		()
		()

I further release my medical information to the following physicians, clinics, and/or hospitals:

Name:	Relationship:	Phone Number:
		()
		()
		()

This authorization for release of medical information is valid until revoked by written notice or replaced with an updated authorization.

Signature: _____ Date: _____

HIPAA Release of Information AUTHORIZATION FORM

I, _____ hereby authorize **Myers Institute, PC** and its affiliates, its employees and
(Patient Name)
agents to release to my personal health information maintained by _____
(Leave Blank)
(e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided
to me and which identifies my name, address, social security number, Member ID number) **except** the following
information about me: _____

for the purpose of helping me to resolve claims and health benefit coverage issues. I also authorize **Myers Institute, PC**
to obtain my medication history from my pharmacy, health plans, and other health care providers. By signing this consent
form I am giving permission to disclose information about my medications that have been filled at my pharmacy or
covered by any insurance plan. I understand that any personal health information or other information released to the
person or organization identified above may be subject to re-disclosure by such person/organization and may no longer
be protected by applicable federal and state privacy laws. This authorization is valid from the date of my/my
representative's signature below and shall expire in one year.

I understand that I have a right to revoke this authorization by providing written notice to **Myers Institute, PC**. However,
this authorization may not be revoked if **Myers Institute, PC**, its employees or agents have taken action on this
authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.
I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign
will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Patient Name: _____
(Print Name)

Patient Signature: _____ **Date:** _____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: _____
(Print Name)

Signature of Legal Representative: _____ **Date:** _____

Name of Witness: _____
(Print Name)

Signature of Witness: _____ **Date:** _____

Patient Photograph Release Form

Patient's Name _____ Date of Birth _____

Photograph Consent and Release

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 Myers Institute of Plastic and Hand Surgery** medical staff. I hereby give my consent for The **Myers Institute, PC** to use the photographs under one of the following circumstances.

Please initial one of the following:

_____ **Internet:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at **The Myers Institute, PC** can be used on the company's website in order to inform the public about plastic surgery methods. Further, I release and discharge **The Myers Institute, PC**, any employees and the American Society of Plastic Surgeons; and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name or any other identifying marks at any time during any use or publication of these materials by any party.

_____ **All Media:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at **The Myers Institute, PC** can be used in any print or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet, and television, in order to inform the public about plastic surgery methods. Further, I release and discharge **The Myers Institute, PC**, and the American Society of Plastic Surgeons; and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

_____ **Medical Care Only:** Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with **The Myers Institute, PC**. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at **The Myers Institute, PC**.

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other photo consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

Signature (Patient or Parent/Guardian if Patient is under 18)

Date Signed

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.

Co-payments are due at time of service.

If my plan requires a referral, I must obtain it prior to my visit.

In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.

If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to (Dr. Robert Myers OR The Myers Institute of Plastic and Hand Surgery) on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize (Dr. Robert Myers OR The Myers Institute of Plastic and Hand Surgery) to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in (Dr. Robert Myers OR The Myers Institute of Plastic and Hand Surgery). I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

In consideration of services rendered or to be rendered, the undersigned agrees to pay all costs of collection and/or reasonable attorney fees, should the account be turned over to enforce collection of said charges. The undersigned hereby waives all claims or rights of exemption allowed by the constitution of the state of Alabama or any other state of the United States.

Signature of Patient, Authorized Representative or Responsible Party

Date

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient