

PATIENT NAME _____	PATIENT OCCUPATION _____
STREET 1 _____	PATIENT EMPLOYER _____
STREET 2 _____	STREET 1 _____
CITY _____	STREET 2 _____
STATE & ZIP _____	CITY _____
HOME PHONE _____	STATE & ZIP _____
CELL PHONE _____	EMPLOYER'S PHONE _____
WORK PHONE _____	PHARMACY NAME _____
E-MAIL ADDRESS _____	CITY AND PHONE _____
DATE OF BIRTH _____	PATIENT PRIMARY CARE DOCTOR
MARITAL STATUS _____	NAME _____
SOCIAL SECURITY NUMBER _____	ADDRESS _____
RACE _____	CITY, STATE & ZIP _____

(WHITE, BLACK, HISPANIC, ASIAN, INDIAN, NATIVE AMERICAN ESKIMO, OTHER)

BILLING/ACCOUNT INFORMATION:

PRIMARY CARDHOLDER	INSURANCE INFORMATION
NAME _____	PRIMARY INSURANCE COMPANY _____
STREET 1 _____	PRIMARY INSURANCE POLICY HOLDER/SUBSCRIBER NAME/DOB _____
STREET 2 _____	WHAT COMPANY/ORGANIZATION/EMPLOYER PROVIDES THIS INSURANCE COVERAGE? _____
CITY _____	WHAT IS THE EMPLOYMENT STATUS OF THE POLICY HOLDER/SUBSCRIBER? _____
STATE & ZIP _____	<small>(FULL-TIME, PART-TIME, STUDENT, PART-TIME STUDENT, RETIRED, UNEMPLOYED, SELF-EMPLOYED, UNKNOWN)</small>
HOME PHONE _____	
CELL PHONE _____	
WORK PHONE _____	
DATE OF BIRTH _____	
MARITAL STATUS _____	
SOCIAL SECURITY NUMBER _____	

CARDHOLDER'S EMPLOYER:

NAME _____	SECONDARY INSURANCE COMPANY _____
STREET 1 _____	SECONDARY INSURANCE POLICY HOLDER/SUBSCRIBER NAME _____
STREET 2 _____	WHAT COMPANY/ORGANIZATION/EMPLOYER PROVIDES THIS INSURANCE COVERAGE? _____
CITY _____	WHAT IS THE EMPLOYMENT STATUS OF THE POLICY HOLDER/SUBSCRIBER? _____
STATE & ZIP _____	<small>(FULL-TIME, PART-TIME, STUDENT, PART-TIME STUDENT, RETIRED, UNEMPLOYED, SELF-EMPLOYED, UNKNOWN)</small>
HOME PHONE _____	
CELL PHONE _____	
OCCUPATION _____	

FOR NEW PATIENTS:

How were you referred to our clinic or what helped you choose our clinic? Please check one.

<input type="checkbox"/> Newspaper	<input type="checkbox"/> Spa	<input type="checkbox"/> Website
<input type="checkbox"/> Real Self	<input type="checkbox"/> Event	<input type="checkbox"/> Internet Social
<input type="checkbox"/> Specialty Magazine	<input type="checkbox"/> Radio	<input type="checkbox"/> Media
<input type="checkbox"/> Physician Referral	<input type="checkbox"/> Family/Friend	
<input type="checkbox"/> ER Visit	Name: _____	
<input type="checkbox"/> Insurance	Can we thank them? <input type="checkbox"/> YES <input type="checkbox"/> NO	

You must provide all insurance cards at the time of registration.

Please fill out all pages in this new patient packet.

Co-payments are due at each visit.

All payments are to be made payable to:
Burt & Will Plastic Surgery, SC.

Thank you for choosing Burt & Will Plastic Surgery and Dermatology.

Please indicate daily consumption or prior history of each of the following:

PATIENT NAME _____
 OCCUPATION _____

TOBACCO _____
 ALCOHOL _____

PAST MEDICAL HISTORY/FAMILY HISTORY:

Conditions/Disease	Yourself	Blood Relative
Basel Cell Skin Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Melanoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Squamous Cell Skin Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal Moles on Biopsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Actinic Keratosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies/Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis/Liver Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

ADOPTED? YES NO

Conditions/Disease	Yourself	Blood Relative
HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Skin Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psoriasis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of Blood Transfusions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis (TB)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

PERTINENT PREOPERATIVE INFORMATION:

- Have you ever reacted badly to being put to sleep for surgery? Yes No
- Has any member of your family ever reacted badly to being put to sleep during surgery? Yes No
- Have you required large amounts of local anesthetic for medical or dental procedures? Yes No
- Have you ever had a bad reaction to local anesthetic (Novocain, etc.)? Yes No
- Are you allergic to adhesive tape? Yes No
- Do you bleed unusually easily (from cuts, surgery, tooth extraction, etc.)? Yes No
- Do you bruise easily? Yes No
- Have you required transfusion for surgery? Yes No
- Are you a slow or poor healer? Yes No
- Do you form large scars or keloids? Yes No
- Do you have any skin disease, hives, eczema or rashes? Yes No
- Do you have frequent infections or boils? Yes No
- Do you have shortness of breath with walking? Yes No
- Does your religion prohibit blood transfusions? Yes No
- Do you have, or have you had, any significant emotional problems? Yes No
- Have you ever been advised to see a psychiatrist? Yes No
- Are you pregnant? Yes No
- Have you had a mammogram? If yes, when? _____ Yes No

Burt & Will Plastic Surgery and Dermatology Patient Registration | Date: _____

PATIENT NAME _____ DOB _____ AGE _____

MEDICAL HISTORY

REASON FOR VISIT: _____

REFERRING PHYSICIAN: _____

Street 1: _____

Street 2: _____

City: _____

State & Zip: _____

HEIGHT: _____ WEIGHT: _____ Weight loss or gain in the past year? YES NO

Amount of weight: Loss _____ Gain _____

When was your most recent physical check-up: _____

MEDICAL CONDITIONS: Mark all that apply

- Heart Disease
- High Blood Pressure
- High Cholesterol
- Diabetes
- Chronic Lung Disease

Other: _____

MEDICATIONS:

DOSAGE:

FREQUENCY:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any medications?

MEDICATION/DRUG:

REACTION:

_____	_____
_____	_____

SURGERIES & HOSPITALIZATION HISTORY:

DATES:

_____	_____
_____	_____

Are you interested in any of the following procedures?

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Rhinoplasty | <input type="checkbox"/> Eyelid Surgery | <input type="checkbox"/> Liposuction | <input type="checkbox"/> Hair Restoration | Breast: <input type="checkbox"/> Augmentation |
| <input type="checkbox"/> Face/Brow Lift | <input type="checkbox"/> Abdominoplasty | <input type="checkbox"/> Botox/Fillers | <input type="checkbox"/> Laser Treatments | <input type="checkbox"/> Reduction |
| | | | | <input type="checkbox"/> Lift |

Would you like to learn more about our full-service spa, Limelight Medspa & Cosmetic Laser Centre? YES NO

Burt & Will Plastic Surgery and Dermatology Patient Registration

RECEIPT OF NOTICE OF PRIVACY FORM

I, _____, hereby acknowledge receipt of the Physician's Notice of Privacy Practices. The Notice of Privacy provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any revised notice will be provided to me or made available upon my request.

In the event that Burt & Will Plastic Surgery and Dermatology or Limelight Medical Spa is unable to contact me, I give full permission to Burt & Will Plastic Surgery and Dermatology or Limelight Medical Spa to contact the individual that I have designated below for the purpose of disclosing information pertinent to my case. This would include, but is not limited to, information regarding tests, reports, scheduling and business information. By my signature below, I agree to hold harmless and waive any liability against Burt & Will Plastic Surgery and Dermatology or Limelight Medical Spa for the disclosure of information to the individual(s) designated below.

NAME

PHONE

Signature of Patient _____ Date _____

If you are not the patient, please specify your relationship to the patient: _____

CONSENT FOR RELEASE AND USE OF PHOTOGRAPHS (FOR MEDICAL CHART USE ONLY)

I, _____, am a patient of Tripti Burt, M.D., Neena Will, M.D. and/or Yazan Alghalith, M.D., and have been photographed during the course of my treatment. I grant Burt & Will Plastic Surgery and Dermatology the ongoing right to use the pre and post-operative photographs of the undersigns. The undersigned acknowledges that he/she relinquishes all right, title and interest in the photographs, or any right to profit or gain directly realized through the use of photographs. This form and the effect of my consent have been fully explained to me and any questions I have are fully answered. These photographs are used as part of my medical records.

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

FINANCING

We offer financing for both our cosmetic spa and surgical services, which includes CareCredit. Ask to speak with Thalia for more details or if you have any questions.

Burt & Will Plastic Surgery and Dermatology Financial Policy

Thank you for choosing Burt & Will Plastic Surgery and Dermatology and/or Limelight Medical Spa as your health care provider. Please understand that payment of your bill is considered a part of your treatment. Your clear understanding of our financial policy is important to our professional relationship.

All patients must complete our "Patient Registration and Medical Form" prior to seeing the doctor.

- Co-pays are due at the time of service.
- There will be a \$35.00 service charge on all returned checks.
- The charges made for your visit depend on the nature and the complexity of your problem. If you have any questions regarding the charges made for any visit, please feel free to contact our billing office.
- Any charges that become sixty (60) days old without satisfactory payment provisions having been made will be considered delinquent and charged a \$15.00 statement fee for each statement sent out. We reserve the right to turn over delinquent accounts to a debt collector agency or an attorney for collection. Costs associated with the collection efforts will be added to the balance due to Burt & Will Plastic Surgery and Dermatology and/or Limelight Medical Spa.
- We accept cash, checks, Visa, MasterCard, Discover and CareCredit.

Cosmetic Consultation Fee

- A \$50.00 cosmetic consultation fee is due at the time of the initial consult.
- This fee covers the initial consult with either Dr. Burt or Dr. Will.
- If you see both Dr. Burt and Dr. Will, the fee is \$50.00 for each physician.
- This applies to consults for cosmetic procedures only.

Cosmetic Surgery Policy

- A scheduling fee of \$500.00 is due at the time of the preoperative appointment or time of surgery scheduling.
- This fee is non-refundable and will be deducted from the surgery fee.
- The surgery fee is due in full two weeks prior to the date of surgery.
- A cancellation the day of surgery will result in a 100% cancellation fee.

Burt & Will Plastic Surgery and Dermatology and/or Limelight Medical Spa is not responsible for errors in billing made by third party vendors such as Chase Credit, CareCredit, Visa, MasterCard, Discover, etc.

Medicare—I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801–3812 provides penalties for withholding this information) Regulations pertaining to Medicare assignment of benefits also apply.

Illinois Health Partners HMO—A referral from your primary care physician is required at the time of your appointment.

Covered Services—Some health plans do not cover all services. If we are aware that your plan excludes certain services you will need to pay for those services at the time they are rendered.

If you do not currently have medical insurance, a fee of \$250.00 will be required at the initial physician visit.

I understand the above listed financial policy and agree to abide by this agreement.

SIGNATURE: _____ **DATE:** _____

Release of Information and Authorization for Assignment of Benefits

I authorize the physician(s), staff and surgical assistants directed by the physician to do any medical treatment test or care deemed necessary. I authorize Burt & Will Plastic Surgery and Dermatology to release to my insurance company or its representatives information including the diagnosis and the records of any treatment or examination rendered to me that they may require processing my claim for benefits. I authorize and request that my insurance company pay directly to the above named practice the amount due to me in my pending claim for medical treatment of services, by reason of such treatment or services rendered to me. This assignment will remain in effect until revoked by me in writing. I understand and agree that, regardless of my insurance policy, I am responsible for the entire balance on my account, for all professional services provided to the patient (or myself). I have read all the information contained in the financial policy. I certify that, to the best of my knowledge, this information completed is correct and true. I will notify this office in case of any changes to my health or any of the attached information.

SIGNATURE: _____ **DATE:** _____