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

PATIENT NAME _____
STREET 1 _____
STREET 2 _____
CITY _____
STATE & ZIP _____
HOME PHONE _____
CELL PHONE _____
WORK PHONE _____
E-MAIL ADDRESS _____
DATE OF BIRTH _____
MARITAL STATUS _____
SOCIAL SECURITY NUMBER _____
RACE _____
(WHITE, BLACK, HISPANIC, ASIAN, INDIAN, NATIVE AMERICAN ESKIMO, OTHER)

PATIENT OCCUPATION _____
PATIENT EMPLOYER _____
STREET 1 _____
STREET 2 _____
CITY _____
STATE & ZIP _____
EMPLOYER'S PHONE _____
PHARMACY NAME _____
CITY AND PHONE _____

PATIENT PRIMARY CARE DOCTOR
NAME _____
ADDRESS _____
CITY, STATE & ZIP _____

BILLING/ACCOUNT INFORMATION:

PRIMARY CARDHOLDER
NAME _____
STREET 1 _____
STREET 2 _____
CITY _____
STATE & ZIP _____
HOME PHONE _____
CELL PHONE _____
WORK PHONE _____
DATE OF BIRTH _____
MARITAL STATUS _____
SOCIAL SECURITY NUMBER _____

INSURANCE INFORMATION
PRIMARY INSURANCE COMPANY _____
PRIMARY INSURANCE POLICY HOLDER/SUBSCRIBER NAME/DOB _____
WHAT COMPANY/ORGANIZATION/EMPLOYER PROVIDES THIS INSURANCE COVERAGE? _____
WHAT IS THE EMPLOYMENT STATUS OF THE POLICY HOLDER/SUBSCRIBER? _____
(FULL-TIME, PART-TIME, STUDENT, PART-TIME STUDENT, RETIRED, UNEMPLOYED, SELF-EMPLOYED, UNKOWN)

CARDHOLDER'S EMPLOYER:

NAME _____
STREET 1 _____
STREET 2 _____
CITY _____
STATE & ZIP _____
HOME PHONE _____
CELL PHONE _____
OCCUPATION _____

SECONDARY INSURANCE COMPANY _____
SECONDARY INSURANCE POLICY HOLDER/SUBSCRIBER NAME _____
WHAT COMPANY/ORGANIZATION/EMPLOYER PROVIDES THIS INSURANCE COVERAGE? _____
WHAT IS THE EMPLOYMENT STATUS OF THE POLICY HOLDER/SUBSCRIBER? _____
(FULL-TIME, PART-TIME, STUDENT, PART-TIME STUDENT, RETIRED, UNEMPLOYED, SELF-EMPLOYED, UNKOWN)

FOR NEW PATIENTS:

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

- ❑ Newspaper
- ❑ Real Self
- ❑ Specialty Magazine
- ❑ Physician Referral
- ❑ ER Visit
- ❑ Insurance
- ❑ Spa
- ❑ Event
- ❑ Facebook
- ❑ Family/Friend
- ❑ Website
- ❑ Internet
- ❑ Instagram
- ❑ ZocDoc

Name: _____
Can we thank them? ❑ YES ❑ 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.

Burt & Will Plastic Surgery and Dermatology Medical Form | 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 ❑ None

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

Other: _____

MEDICATIONS: ❑ None DOSAGE: FREQUENCY:

Are you allergic to any medications? ❑ None

MEDICATION/DRUG: REACTION:

SURGERIES & HOSPITALIZATION HISTORY: ❑ None DATES:

Are you interested in any of the following procedures?

- ❑ Rhinoplasty
- ❑ Face/Brow Lift
- ☐ Arm/Thigh Lift
- ❑ Eyelid Surgery
- ❑ Abdominoplasty
- ☐ BBL
- ❑ Liposuction
- ❑ Botox/Fillers
- ☐ Skin Check
- ❑ Hair Restoration
- ❑ Laser Treatments
- ☐ Weight Loss Program

Breast: ❑ Augmentation ❑ Reduction ❑ 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 Medical Form | Date: _____

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

PATIENT NAME _____ TOBACCO _____

OCCUPATION _____ ALCOHOL _____

PAST MEDICAL HISTORY/FAMILY HISTORY:

ADOPTED? ❑ YES ❑ NO

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

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

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. That 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 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 questions I have 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 the Practice Administrator 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 changes 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: _____