EADES PLASTIC SURGERY

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Cell #: _____ Home #: _____ E-mail: _____

Referred by: _____

Please Circle: Married Single Widowed
Spouse / Partner's Name: _____

Gender Identity (please circle): Male Female Trans Man Trans Woman
Non-conforming Other: _____
Decline to Answer

EMERGENCY NOTIFICATION

Name: _____ Relationship: _____ Phone: _____

GUARANTOR INFORMATION (For a minor patient or if other than patient)

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Cell #: _____ Home # _____ E-mail: _____

MEDICAL HISTORY

Please circle any of the medical problems listed below that apply to you (past or present)

Dry Eye	Blood clots in legs	Anxiety
Tearing	Bleeding tendency	Depression
Heart disease	Breathing problems	Migraines
High blood pressure	Chronic cough	Mood disorder
Chest pain	Hepatitis	Artificial joints
Previous heart attack	Kidney problems	Neck pain/stiffness
Pacemaker	Diabetes	Cold sores
Mitral valve prolapse	Thyroid disease	Lupus
Rheumatic fever	Cancer: _____	HIV / AIDS
Heart murmur	Seizures	

Additional medical conditions: _____

_____

Please list any allergies to medications and your reaction to them:

Medication	Reaction
_____	
_____	
_____	
_____	

WOMEN ONLY:

Is there a chance you may be pregnant?	Yes	No
Do you use birth control pills?	Yes	No
Are you on hormone replacement therapy?	Yes	No
Do you have a family history of breast cancer?	Yes	No

Date of last mammogram? _____ Results: _____

SOCIAL HISTORY

Do you smoke cigarettes? Yes No

If yes: How much? _____ For how long? (years) _____

Do you use a nicotine patch or gum? Yes No

Do you use smokeless tobacco? Yes No

Do you drink alcohol, beer, or wine? Yes No If yes, how many drinks/day? _____

SURGICAL HISTORY

Type	Date

Did you experience any problems or complications during or following surgery? Yes No
If yes, please explain: _____
_____

Do any members of your biological family have bleeding tendencies or problems related to local or general anesthetics? Yes No
If yes, please explain: _____
_____

Please list any medications you are currently taking:

	Medication	Dose	Times per day
1.			
2.			
3.			
4.			
5.			
6.			

Height: _____ Ft _____ In Weight: _____ lbs

Patient signature: _____ Date: _____

Guardian signature: _____ Date: _____

HIPAA Disclosure Form

Hospital: N/A Doctor: N/A

Patient Name: _____ Date: _____

Listed Address: _____

Preferred Correspondence Address: _____

Listed Phone No. _____ Preferred Phone No. _____

Listed Email Address: _____

Preferred Email Address: _____

Would you like our correspondence with you to be marked "Confidential"? ❑ Yes ❑ No

May we identify ourselves over the phone? ❑ Yes ❑ No May we leave messages? ❑ Yes ❑ No

I, the Patient, hereby authorize the doctor and/or hospital listed above to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

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

Doctor: _____ Clinic: _____ Phone: _____

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Doctor: _____ Clinic: _____ Phone: _____

Doctor: _____ Clinic: _____ Phone: _____

Doctor: _____ Clinic: _____ Phone: _____

EADES PLASTIC SURGERY FINANCIAL POLICY

We want you to have a clear understanding of our financial policy to make our relationship as successful as possible. Payment policies are explained below.

In-Office Procedures: Payment is due in full at the time of your appointment for the procedure.

Cosmetic Surgery: Payment for cosmetic surgery is to be paid in full a minimum of 10 business days prior to your surgery. If payment is not received by 5 business days prior to your surgery, we reserve the right to cancel your surgery. If your surgery is canceled, $500 non-refundable deposit will then be required to reschedule.

Additional Surgery: During the first year after your surgery, any revision or touch-up procedures related to your original cosmetic surgery that are simple enough to be done in the office under local anesthesia will be done at no charge. If additional surgery such as a take-back for post-op bleeding or a revision of your original cosmetic surgery needs to be performed in the hospital or outpatient surgery center, Dr. Eades's fee will be waived during that first year, however, you will be responsible for any facility and anesthesia fees, and supplies (like implants, for example).

Garments: When indicated for use, one post-op garment will be provided to you. If you prefer an extra garment, a different style or a lighter one, you may purchase one from us or from a retailer (Amazon, Target, etc.).

Cancellation Policy: Surgery requires careful planning, ordering of supplies and implants, surgical equipment and coordination between several individuals. Please understand that if you cancel your surgery 5 business days or less from your surgery date this will result in a 10% loss of your prepaid fees. Extenuating circumstances will be evaluated on a case-by-case basis.

Pre-operative Testing: Depending on your age and medical history the surgical facility where your procedure is to be performed may require pre-operative testing such as an EKG or bloodwork. The costs for these tests are not included in

the price quote for your surgery but can typically be billed to your medical insurance.

The practice of medicine is not an exact science and reputable surgeons cannot guarantee results. There are many internal and external variables that influence your healing process and your results. Not all these variables are under Dr. Eades's control and therefore the results of certain procedures may not last for as long as expected or meet the degree of your expected improvement. Cosmetic surgery is not a "consumer product" and it is important that you understand that all services are non-refundable. Additionally, if complications should develop or surgical revisions become necessary, you may incur additional costs.

Printed Patient Name: _____

Patient Signature: _____

Date: _____

EDWARD EADES, M.D.

TUCSON, ARIZONA 85712

PHONE: 520-323-6994

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received
(Name of Patient)

a copy of EDWARD EADES, M.D.'s **'Notice of Privacy Practices'.** This Notice describes how EDWARD EADES, M.D. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____
(Signature of Patient, or Personal Representative) (Date)

_____
(Relationship to Patient)