CANNON
Plastic & Reconstructive Surgery

PATIENT INFORMATION SHEET

Date:_____

Patient Name _____
Last First Middle

Sex _____ Date of Birth _____ Age _____ Social Security #_____

Home Address _____
Street City/ State/ Zip

Primary Phone Number _____ Secondary Phone Number _____

Email Address _____

Employer _____ Phone Number _____

Primary Care Physician _____

Referred by _____

Reason For Your Visit _____

****

I, _____, represent to Dr. Cannon and staff that I am at least 18 years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and the treatment by Dr. Cannon and such assistant or staff as may be assigned by him/her. I authorize that release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of any medial information for the purpose of processing insurance claims on my behalf. I authorize payments of any medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. In the event of any litigation arising from treatment, I agree to submit the case to arbitration. I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize the taking of photographs at the direction of my surgeon and under such conditions as may be approved by him/her. These photographs will be used solely for documentation purposes and will be kept confidential.

I understand that there may be a consultation fee for the initial visit which is due at the time of my appointment unless other arrangements have been made in advance.

SIGNATURE:_____ DATE:_____

RELATIONSHIP: (Circle One) PATIENT SPOUSE PARENT GUARDIAN

INSURANCE INFORMATION

Primary Insurance Company _____

ID/ Policy # _____ Group # _____

Policy Holder's Name _____

Policy Holder's SS# _____ DOB _____ Sex _____

Patient's Relationship to Policy Holder _____

Secondary Insurance Company _____

ID/ Policy # _____ Group # _____

Policy Holder's Name _____

Policy Holder's SS# _____ DOB _____ Sex _____

Patient's Relationship to Policy Holder _____

ACCIDENT – AUTO
If your injury is a result of an auto accident, please fill out this section.

Auto Insurance Co Name _____ Policy # _____

Policy Holder's Name _____

Date Accident Occurred _____

WORKMEN'S COMPENSATION
If your accident is an incident that occurred on the job, please fill out this section.

Employer _____

Supervisor _____ Telephone Number _____

Date of Injury _____ Was injury reported to employer? Yes____ No____

Tell us how injury occurred: _____

_____

_____

SIGNATURE: _____ DATE: _____

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MEDICAL HISTORY

Name _____ Date_____

Date of Birth_____ Age_____ Height_____ft._____in. Weight_____lbs.

Chief Complaint: _____

SIGNIFICANT MEDICAL HISTORY:

Medical Allergies/Sensitivities:_____ Pregnant? N Y

List ALL Medications, Including Non-Prescription Supplements (vitamins, herbs, etc.): _____

_____

_____

Are you a smoker? Y N How many packs per day:_____ For how many years?_____

Do you drink alcohol? Y N Amount: _____

Do you exercise? Y N Amount:_____

Do you use illicit drugs? Y N Type:_____

Personal Medical History								
Abnormal Bleeding	**Y**	**N**	Asthma	**Y**	**N**	Hypertension	**Y**	**N**
Abnormal Clotting	**Y**	**N**	Diabetes	**Y**	**N**	Sleep Apnea	**Y**	**N**
Acid Regurgitation	**Y**	**N**	Heart Attack	**Y**	**N**	Hyperlipidemia	**Y**	**N**
Anemia	**Y**	**N**	Heart Failure	**Y**	**N**	Scarring/Keloid	**Y**	**N**
Angina	**Y**	**N**	Hepatitis	**Y**	**N**	Stroke	**Y**	**N**
Other Medical Illness:								

Past Surgical History: List all operations you have had, including plastic surgery.	
Operation	**Date**

Have you ever had: Local Anesthesia Y N General Anesthesia Y N
List any complications/reactions that you may have experienced with anesthesia: _____

_____

Family Medical History	
Abnormal Bleeding **Y N**	Asthma **Y N**
Abnormal Clotting **Y N**	Diabetes **Y N**
Anesthesia Problems **Y N**	Heart Attack **Y N**
Cancer **Y N Describe:**	Hypertension **Y N**
Please Describe any other illness in your family:	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing inaccurate information can be dangerous to my health.

Patient Signature:_____ Date: ____/____/____

Cliff Cannon III, MD: _____ Date: ____/____/____

Review of Symptoms – Please circle any of the following that you are experiencing.

General
Weight change
Sleep changes
Appetite change
Fatigue
Fever/chills

Head
Headache
Head injury

Eyes
Vision change
Blurriness/
Double vision
Pain
Redness
Flashing lights
Glaucoma
Cataracts

Ears
Decreased
hearing
Ringing
Earache
Discharge

Nose
Stuffiness
Discharge
Itching
Hay fever
Nosebleeds
Sinus pain

Throat
Problems with
teeth or gums
Dry mouth
Sore throats
Hoarseness

Neck
Lumps
Swollen glands
Pain
Stiffness

Skin
Rashes
Bruising
Lumps
Itching
Dryness
Color change
Change in hair or
nails
Delayed healing
Disfigured
scarring
Thickened
scarring
Keloid formation

Neurological
Dizziness
Lightheadedness
Fainting
Seizures
Weakness
Paralysis
Numbness
Tingling

Endocrine
Heat or cold
intolerance
Excessive
sweating
Excessive
urination
Change in glove
or shoe size

Respiratory
Cough
Sputum
Blood
Difficulty
breathing
Wheezing
Pain
TB exposure
Pulmonary
Embolus

Cardiovascular
Chest pain
Tightness
Palpitations
Leg edema

GI
Trouble
swallowing
Appetite change
Nausea
Heartburn
Bloody stool
Constipation
Diarrhea
Pain
Jaundice
Tarry stools
Change in bowels

GU
Frequency
night urination
Urgency
Burning
Blood in urine
Infections
Kidney stones
Incontinence
Hesitancy

Blood
Claudication
Leg cramps
Varicose veins
Blood clots
(DVT)
Easy bruising
Easy bleeding
Anemia
History of
transfusion

Musculoskeletal
Muscle or joint
pains
Stiffness
Gout
Back pain
Swelling

Psych
Nervousness
Depression
Memory loss
Stress
Eating disorder
Body dysmorphic
disorder
ADHD
Bipolar

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Patient's Bill of Rights

THE PATIENT HAS THE RIGHT TO

1. Considerate and respectful care.
2. Knowledge of the name of the physician who has primary responsibility for coordinating the care and the names and professional relationships of the other physicians and non-physicians who will see the patient.
3. Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, alternate courses of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.
4. Participate actively in any decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment.
5. Full consideration of privacy concerning the medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for presence of any individual.
6. Confidential treatment of all communications and records pertaining to his/her care.
7. Reasonable continuity of care and to know in advance the time and location of appointment as well as identity of persons providing the care.
8. Be advised if the physician's purpose if to engage in or perform human experimentation affecting care or treatment. The patient has the right to refuse to participate in such projects.
9. Have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
10. Have complaints forwarded to administrative personnel for appropriate response.
11. Know that all the clinic/office personnel will observe these patients' rights.

PATIENT'S RESPONSIBILITIES

1. The care that a patient receives depends partially on the cooperation of the patient. In addition to those rights, a patient must acknowledge and adhere to certain responsibilities.
2. The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past medical history, and other matters relating to his/her health.
3. The patient is responsible for making it known whether he/she dearly comprehends the course of medical treatment and what is expected of him/her.
4. The patient is responsible for following the treatment plan established by his/her physician, including the instructions of the nurse or other health professionals as they carry out the physician's orders.
5. The patient is responsible for keeping appointments and for notifying the office when he or she is unable to.
6. The patient is responsible for his/her actions should he/she refuse treatment or choose not to follow his/her physician's orders.
7. The patient is responsible for assuring that the financial obligations of his/her care are fulfilled.
8. The patient is responsible for being considerate of the rights of the other patients and office personnel.

Patient Signature _____ Date_____

Form for E-Prescribing Prescription Electronically

Dear Patients,

As we are transferring to electronic medical recording, we would like to help accommodate you by transmitting your prescriptions electronically. Please provide us with the following information for E-Prescribing:

Patient name: _____

Name of your Pharmacy:_____

Pharmacy Phone Number:_____

Pharmacy Location: _____
(Full address)

_____

_____

** If you should change your pharmacy in the future, please notify us so we can update our records.

Thank you,

Cannon Plastic & Reconstructive Surgery

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Smoking Risk Consent

Patient: _____ Age: _____

1. I am not a smoker.
2. I quit _____ months (or) _____ years ago.
3. I currently smoke _____ a day.

Patient Signature _____ Date _____

I have been advised by Dr. Cliff Cannon and his staff that I must not smoke or take nicotine substitutes for a minimum of six (6) weeks before my surgery. I have also been advised that being in the presence of second-hand smoke can compromise my surgery and it outcome.

It has been explained to me that the risks of surgery are much greater for smokers, and even if I am off cigarettes for six (6) weeks before and after surgery I may still experience the effects of nicotine.

There is greater risk in smokers for bad scarring, hematoma formation, intra-operative bleeding, bleeding, poor or delayed healing, hair loss, sloughing of the skin (skin loss), infection, increased or prolonged bruising and hyper-pigmentation.

I ACKNOWLEDGE THAT I HAVE READ AND FULLY UINDERSTAND THE ABOVE CONSENT TO OPERATE, THAT THE RISKS HAVE BEEN FULLY EXPLAINED TO ME, AND I WISH TO PROCEED WITH SURGERY.

Patient Signature _____ Date_____

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Cancellation & No Show Policy

1. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" schedule.

   If an appointment is not cancelled at least 24 hours in advance you will be charged a forty dollar ($40) fee; this will not be covered by your insurance company.

2. **Scheduled Appointments**

   We understand that delays can happen, however we must try to keep the other patients and providers on time.

   If a patient is 20 minutes past their scheduled time, we will have to reschedule the appointment.

3. **Account Balances**

   We will require that patients with a no show fee on their account pay their balance to zero prior to receiving further services by our practice.

Patient Name Printed	Signature of Patient/ Guardian	Date

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your healthcare provider or staff of Cannon Plastic and Reconstructive Surgery to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I do not authorize Cannon Plastic and Reconstructive Surgery to release any or all information concerning my medical care to any individual except as set for above.

_____ I do authorize Cannon Plastic and Reconstructive Surgery to verbally release any or all information concerning my medical care to the following individuals:

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

_____ _____

Patient Signature Date

_____

Print Patient Name Date of Birth Social Security Number

_____

Witness Signature Date

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Patient Photograph Release Form

Patient 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 Cannon Plastic & Reconstructive Surgery, P.C. medical staff. I hereby give my consent for Cannon Plastic & Reconstructive Surgery, P.C. to use the photographs under the following circumstances:

Please initial the following:

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

_____ **Internet**: Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Cannon Plastic & Reconstructive Surgery, P.C. can be used on the company's website in order to inform the public about plastic surgery methods. Further, I release and discharge Cannon Plastic & Reconstructive Surgery, P.C., any employees of Cannon Plastic & Reconstructive Surgery, P.C., 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 Cannon Plastic & Reconstructive Surgery, P.C., 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 Cannon Plastic and Reconstructive Surgery, P.C., any employees of Cannon Plastic & Reconstructive Surgery, P.C., 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.

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

ASSIGNMENT TO MY DOCTOR, AND AUTHORIZATION AND RELEASE OF MEDICAL INFORMATION

1. *Assignment*. I hereby assign to Cannon Plastic and Reconstruction Surgery, P.C., a Georgia professional corporation and Clifton L. Cannon, M.D. (jointly "Cannon") all right, title and interest in and to payment and the benefits and rights of insurance, medical plans, including those subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1002 *et seq*., and all other sources of payment from any and all third parties for and related to medical services ("Services") rendered by Cannon to me. This assignment assigns all my rights including, without limitation, the right to receive payment, to assert and pursue all legal and equitable claims for payment and equitable relief in all forums, to the fullest extent as if Cannon were the undersigned and an insured, participant and party to whatever insurance, medical plans, ERISA plan, and other sources of payment I may be entitled to. If I receive payment at any time from a third party for Services rendered to me by Cannon I promise to pay to Cannon any amounts so received upon receipt.
2. *Authorization and Release*. I direct all payments for Services be made directly to Cannon rather than to me. As I have authorized Cannon to pursue, compromise and collect for Services rendered to me in any forum, I hereby appoint Cannon as my attorney in fact to pursue and all resolve claims related to the Services. Furthermore, I authorize the release of medical information by Cannon to insurance companies, healthcare providers, benefit plans and other payers; including, but not limited to, my primary care or family physician, consulting physicians or healthcare providers, hospitals, rehabilitation centers, or other healthcare providers or facilities; and to such other persons as Cannon reasonably decides.
3. *Request for Information*. I hereby direct, authorize and request that all insurance companies, ERISA plans and other sources of medical benefits provide Cannon, upon receipt of request, any and all policies, plan documents and other information regarding any medical coverage, benefits or rights I have, or might have, which might relate to the Services in anyway.
4. *Release of Medical Information*. I authorize Cannon to obtain medical records and other information from persons and entities identified in section 2 above to assist Cannon in receiving payment for Services or relief of any type. A copy of this authorization may be used and relied upon by those parties to the same extent as if such copy was an original.

_____

Patient:

Date: _____