SOMERSET PLASTIC SURGERY

MICHAEL J. BUSUITO, MD [ ] ANDREW K. GAVAGAN, MD [ ] PRAVIN P. PURI, MD [✓]

Print Legibly

Patient's Name: Last:_____ First:_____ MI:_____

Address _____
Street & Apt # City State Zip

Home #: _____[ ] Cell #: _____[ ] Other # _____[ ] Please ☑ preferred #

E-mail _____ Driver's License #: _____ State _____

Age _____ Birthdate____/____/_____ SS#: _____-_____-_____ Sex ☐ Female ☐ Male

☐ Single ☐ Married Spouse_____ ☐ Other _____

RACE: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Hispanic ☐ OTHER _____ LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ Other_____
Race is a federal requirement mandated by CMS-Centers for Medicare & Medicaid Services – Appropriate Box(s) must be marked

Emergency Contact _____ Relationship to Pt: _____
(Not in your household)

Phone # _____ Address: _____

Patient's Employer _____ Occupation_____

Work Phone _____Ext: _____ Is it okay to call you at work? ☐ No ☐ Yes

Spouses Employer _____ Occupation_____

Referred By: _____

Phone # _____ Address: _____

Primary Care Physician _____

Phone # _____ Address: _____

Primary Health Insurance Company:_____

Policy #: _____Group #: _____ Copay? ☐ No ☐ Yes $_____ Referral Required? ☐ No ☐ Yes

Subscriber: Name: _____ DOB: ____/____/____ Subscriber SS#: _____-_____-_____

Secondary Health Insurance Company _____

Policy #: _____Group #: _____ Copay? ☐ No ☐ Yes $_____ Referral Required? ☐ No ☐ Yes

Subscriber: Name: _____ DOB: ____/____/____ Subscriber SS#: _____-_____-_____

Authorization to pay benefits to physician and release of medical information: I hereby authorize payment directly to Pravi Puri, M.D. of any Surgical and/or medical benefits otherwise payable to me for his services. I hereby authorize Dr. Puri to release any medical information for payment on my insurance claim. I understand I am responsible for payment of all copays and deductible as required by my insurance company.

Signature _____ **Date** _____

SOMERSET PLASTIC SURGERY
HEALTH HISTORY FORM

MICHAEL J. BUSUITO, MD | | ANDREW K. GAVAGAN, MD | | PRAVIN P. PURI, MD [✓]

NAME _____ ☐ Female ☐ Male Age_____
Last First MI

DATE OF BIRTH _____/_____/_____ Height _____ Weight_____

Reason for your visit today _____

MEDICAL CONDITIONS: ✓ appropriate boxes below

- ☐ No Past Medical History
- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anesthesia Problems
- ☐ Autoimmune Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Cancer
- ☐ Cancer _____
- ☐ Chemo Therapy
- ☐ Chest Pain / Tightness
- ☐ Depression / Anxiety
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Heart Murmur
- ☐ Healing Problems _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Post Radiation Therapy
- ☐ Psychiatric Care
- ☐ Skin Cancer
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Transfusion _____

☐ Other _____

FEMALES ONLY:
- ☐ Fibrocystic Breast
- ☐ BRCA Gene Positive
- ☐ Menopause
- ☐ Ovarian Cancer

Plan Becoming Pregnant?
☐ Yes ☐ No
# of Pregnancies _____
Live births _____
Ages of Children _____
Currently Pregnant
☐ Yes ☐ No
Last Mammogram
Normal ☐ Yes ☐ No
Date _____

MEDICATIONS: Attach Sheet if more room is needed
ARE YOU TAKING ASPIRIN ☐ Yes ☐ No Dose _____

DRUG NAME	DOSE	FREQUENCY

Pharmacy _____ Phone _____
Address _____

ALLERGIES : LATEX ☐ Yes ☐ No
Please List All Medication / Substance Allergies

SURGICAL HISTORY List any surgeries / hospitalizations

Description	Year

FAMILY HISTORY ✓ if applicable
- ☐ Breast Cancer – Who _____
- ☐ Diabetes
- ☐ Heart Disease / Stroke
- ☐ High Blood Pressure
- ☐ Hemophilia
- ☐ Malignant Hypothermia / Hyperthermia
- ☐ Ovarian Cancer
- ☐ Skin Cancer
- ☐ Abnormal Bleeding; Abnormal Clotting
- ☐ Other _____

SOCIAL HISTORY ✓ if applicable

Smoking ☐ Yes ☐ No # of Packs daily_____ # years smoked _____
Former Smoker ☐ Yes ☐ No When did you quit? _____ # of Packs daily_____ # years smoked _____
Alcohol ☐ Yes ☐ No # drinks weekly _____ Substance Abuse ☐ Yes ☐ No Caffeine ☐ Yes ☐ No

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Busuito responsible for any omissions / errors I have made in completing this form. This information is confidential and will not be released without consent.

Signature_____ Date_____ Reviewed by_____ Date_____

PERSONAL MEDICATION RECORD

Name: _____ **Date of Birth:** _____

Allergies: _____

Physician: _____ **Physician Phone#:** _____

Pharmacy: _____ **Pharmacy Phone#:** _____

Name of Medication (Prescription, over-the-counter, eye drops, supplements Patches, herbals, inhalers, implanted pumps)	**Dose of Medication** (Example: one 20 mg. tablet)	**When is Medication Taken?** (Examples: three times a day at bedtime)

Patient Signature: _____ Date: _____

(For Office Use Only)

REVIEWED DATE:	**BY:**	**LIST NEW OR CHANGED MEDICATIONS**

KEEP A COMPLETED & UP-TO-DATE CARD WITH YOU AT ALL TIMES

Somerset Plastic Surgery PLLC
1080 Kirts Blvd Suite # 700
Troy, Michigan, 48084
P (248) 362-2300
F (248) 362-5272

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME _____ **DATE** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that ISomerset Plastic Surgery PLLC may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Somerset Plastic Surgery PLLC has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Somerset Plastic Surgery PLLC will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Somerserset Plastic Surgery PLLC to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Somerset Plastic Surgery PLLC has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

Relationship to Patient if signed by another party _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Somerset Plastic Surgery PLLC, 1080 Kirts Blvd., Suite 700, Troy, MI 48084.

FORM Us