SOMERSET PLASTIC SURGERY

MICHAEL J. BUSUITO, MD [ ] ANDREW K. GAVAGAN, MD [ ] PRAVIN P. PURI, MD [✓] CHRISTINA M. BUSUITO, 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 Name) _____ ☐ Other _____

RACE ☐ White / Caucasian ☐ Black / African American ☐ Asian ☐ Hispanic ☐ Other _____ Language ☐ English ☐ Spanish ☐ Other _____
Race is a federal requirement mandated by Civis-Centers for Medicare & Medicaid Services – Appropriate Box (s) must be marked

Emergency Contact _____ Relationship to Patient _____

Phone #_____ Address _____

Patient's Employer _____ Occupation_____

Work Phone _____ Ext:_____ May we contact you at work? ☐ Yes ☐ No

Spouse's Employer _____ Occupation_____

Referred By _____

Phone # _____ Address_____

Primary Care Physician _____

Phone # _____ Address_____

Primary Health Insurance Company _____ Subscriber Name _____

Policy # _____ Group #_____ Subscriber DOB ____/____/____ Subscriber SS# _____

Secondary Health Insurance Company _____ Subscriber Name _____

Policy # _____ Group #_____ Subscriber DOB ____/____/____ Subscriber SS# _____

Authorization to pay benefits to physician and release of medical information: I hereby authorize payment directly to Dr. Pravin P. Puri, M.D. (Somerset Plastic Surgery) of any surgical and/or medical benefits otherwise payable to me for his services. I hereby authorize Dr. Puri (Somerset Plastic Surgery) to release medical information for payment on my insurance claim (s). I understand I am responsible for payment of all copays and deductibles 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 [✓] CHRISTINA M. BUSUITO, 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
- ☐ In 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. Puri 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
Phone (248) 362-2300
Fax (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 (HIPPA), I have certain Patient Rights regarding my protected health information.

I understand that Somerset Plastic Surgery PLLC may use or disclose my protected health information for treatment, payment or health care operations – which means form 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.

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 Somerset 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

I wish to be contacted in the following manner (check all that apply)

° Home Telephone / Cell Phone
° Leave message with detailed information
° Ok to fax information to _____
° Work phone
° Leave Message with call back number only
° Written Communication
° OK to mail to my home address
° OK to mail to work address

Any Family members / friends you wish to release medical information

_____

_____