HORIZONS
PLASTIC SURGERY

NEW PATIENT INFORMATION

First Name	Middle Name/Initial	Last Name	Date

Address	City	State	Zip Code

E-Mail Address	Home Phone	Cell Phone

Birth Date (Mo/Day/Yr)	Sex	Marital Status	SSN

Employer	Employer Address	Employer Phone

Emergency Contact (Not Living With You)	Emergency Phone	Pharmacy Name

ATTENTION ALL INSURANCE PATIENTS:

PLEASE BRING ALL INSURANCE CARD(S) TO THE DESK IF YOU HAVE NOT ALREADY.

Please indicate who is responsible for paying for the patient's bill IF it is someone other than the patient.

First Name	Middle Name	Last Name	SSN

Street Address	City	State	Zip Code

Mailing Address(If Different)	Home Phone

NEW PATIENT

Name:_____

DOB:_____ Age:_____Height: _____Weight:_____

Referring Physician:_____

Primary Care Physician:_____

If not referred by a Physician, how were you referred to the practice?

_____

What will you be seeing the doctor for today? _____

MEDICAL INFORMATION

	SELF	FAMILY		SELF	FAMILY
Diabetes	No Yes	No Yes	GI/Esophageal Reflux	No Yes	No Yes
Hypertension	No Yes	No Yes	Bleeding Tendency	No Yes	No Yes
Cancer	No Yes	No Yes	Ulcer Disease	No Yes	No Yes
Stroke	No Yes	No Yes	Kidney Disease	No Yes	No Yes
Heart Trouble	No Yes	No Yes	Anemia	No Yes	No Yes
Lung Disease	No Yes	No Yes	Tuberculosis	No Yes	No Yes
Seizures	No Yes	No Yes	Anxiety / Depression	No Yes	No Yes
Arthritis	No Yes	No Yes	Skin Cancer	No Yes	No Yes
Asthma	No Yes	No Yes	Sleep Apnea	No Yes	No Yes
Blood Clots	No Yes	No Yes	Latex Allergy	No Yes	-----

Please list any previous hospitalizations / surgeries / serious injuries:

_____

Please list all current medications:

_____

Are you allergic to any medications? Please list and include what reactions you have if taken:

_____

Do you smoke? Yes or No If yes, how much? Do you use alcohol? Yes or No If yes, how much? Are you married, single, widowed, divorced, or separated?

PATIENT'S SIGNATURE/DATE: _____

PHYSICIAN'S SIGNATURE/DATE: _____

HORIZONS
PLASTIC SURGERY

G. MARC WETHERINGTON, M.D., F.A.C.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you are granting consent to HORIZONS PLASTIC SURGERY CENTER and physicians to use and disclose your protected health information for the purposes of treatment, payment and healthcare operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office at (706)235-5119.

You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or healthcare operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

- Patient Name(PRINT): _____ Date: _____
- Patient Signature: _____
- Notice of Privacy Practices Given: _____

Release of Information

Today's Date:_____

In order at allow Horizons Plastic Surgery physicians and employees to discuss patient information with others involved in your treatment or the payment of services rendered, such as your spouse, child, relative, neighbor, care taker, etc., please provide the following information.

PATIENT INFORMATION:

Name: _____ D.O.B: _____

SSN: _____ Phone #: _____

I hereby allow Horizons Plastic Surgery physicians and employees to discuss/ release my medical information, such as appointment reminders, to verify dates and times of appointments, pick up prescriptions, lab results, care or treatment needs, etc., with the following individuals (*if you do NOT want to list anyone's name, please write NONE on the first line*) :

1. Name: _____ Phone #: _____

Relationship to patient: _____

2. Name: _____ Phone #: _____

Relationship to patient: _____

3. Name: _____ Phone #: _____

Relationship to patient: _____

My signature below indicates the following:

I may change the names of the following individuals listed above at any time. Changes must be made in writing. This information applies to all departments at Horizons Plastic Surgery of which I may be a patient.

Patients Name (please print)

Patients Signature: _____

Date: _____

HORIZONS
PLASTIC SURGERY

CONSENT TO PHOTOGRAPHS

I, _____ (print full name) understand that photographs will be taken periodically throughout my treatments. These photographs will be used to monitor progress and other factors. I understand that failure to consent to these photos will give the right to decline my treatment.

I consent to the taking of photographs by Dr. Marc Wetherington, or his designee, of me or parts of my body in connection with the plastic surgery procedures to be performed by Dr. Wetherington.

I understand that I may refuse to authorize the use of any photo documentation and my refusal to consent to the use of my photo documentation will prevent the use of such information, but will not affect the Healthcare Services I presently receive or will receive.

I understand that by signing below Dr. Marc Wetherington need not approach me again for authorization regarding the use of clinical photographs of me.

_____ _____

(Patient Name- Please Print) (Witness Name- Please Print)

_____ _____

(Patient Signature) _____ (Witness Signature)

(TODAY'S DATE)

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PLASTIC SURGERY

G. Marc Wetherington M.D.
Diplomat, American Board of Plastic Surgery
406 E. 2nd Ave.
Rome, Georgia 30161
Phone: (706)235-5119
Fax: (706)235-5259
www.HorizonsPlasticSurgery.com

Authorization to Release Medical Information

_____Request and Authorize_____

To release all or any medical records for any treatment given. Release my medical records to:

Dr. G Marc Wetherington

406 E. 2nd Ave

Rome, Georgia 30161

Patient Signature:_____

Date of Birth: _____

Today's Date: _____

Witness: _____

Date: _____

HORIZONS
PLASTIC SURGERY

G. Marc Wetherington M.D.
Diplomat, American Board of Plastic Surgery

Member
AMERICAN SOCIETY OF PLASTIC SURGEONS

MEMBER OF THE AMERICAN SOCIETY FOR AESTHETIC PLASTIC SURGERY

406 East Second Avenue
Post Office Box 468
Rome, Georgia 30162-0468

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Cancellation Policy

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That's why it is very important that you keep your scheduled appointment with us and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Horizons Plastic Surgery calls the day before.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours notice.

If you do not cancel or reschedule your appointment with at least 24 hours notice, we may assess a $50 "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it.

I understand the "no-show" policy of Horizons Plastic Surgery and agree to provide a credit card number, which may be charged $50 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no-show charge to the credit card provided.

Credit Card # _____ Exp Date._____ CVV _____

Zip Code Associated with card _____

Patient Signature

_____

Date

_____