HANEMANN

PLASTIC SURGERY

Patient Information

Date:_____ Social Security No.:_____ Referred By:_____

Patient's Name:_____ Date of Birth:_____ Age:_____

Marital Status: S M W D Sep. Sex: M F

Address:_____ City:_____ State:_____ Zip:_____

Home Telephone:_____ Cell #:_____ Work Telephone:_____

Patient's Employer:_____ City:_____ State:_____ Zip:_____

Email Address:_____

Spouse's/Parent's Name:_____ SS#:_____ Date of Birth:_____

Spouse's Telephone:_____ Cell#:_____ Work Telephone:_____

Spouse's/Parent's Employer:_____ Occupation:_____

Employer's Address:_____ City:_____ State:_____ Zip:_____

Pharmacy Name: _____ Telephone #: _____

Pharmacy Address:_____ City:_____ State:_____ Zip:_____

In Case of Emergency Notify (other than Responsible Party)

Name:_____ Phone:_____ Relationship:_____

Address:_____ City:_____ State:_____ Zip:_____

Explanation of Payment Policy and Insurance Filing Procedures

I hereby authorize Hanemann Plastic Surgery to release any and all information acquired in my examination and treatment to my insurer listed above. If I am covered by Blue Cross, Medicare, and/or Medicaid I will furnish my insurance card and signature. If I am covered by other insurance, I will furnish the necessary forms to this office.

I hereby assign and authorize payment directly to the above named clinic. Any medical and surgical benefits otherwise payable to me, should an insurance payment be received that is less than the physician's usual charge for the services provided, I will be responsible for the difference.

I also agree to pay all cost of collection including, but not limited to reasonable attorney's fees, and waiver all claims of exemption under the law of the state of Louisiana. There is a $25 fee charged for all checks returned for insufficient funds.

I authorize treatment by Hanemann Plastic Surgery physicians and personnel.
****Form must be signed and dated by patient or responsible party.**

Date:_____ **Signature:**_____

HANEMANN PLASTIC SURGERY

Name: _____ Date: _____

What Procedure are you interested in? _____

Patient Height : _____ Patient Weight: _____

Habits:

Smoke	Y	N	Amount: _____	
Vape	Y	N	Amount: _____	
Other Tobacco Products	Y	N	Amount: _____	
Coffee/Tea/Soda	Y	N	Amount: _____	
Alcohol	Y	N	Amount: _____	
Exercise	Y	N	Amount: _____	

Medications (list prescription & non-px)

_____

_____

_____

_____

_____

_____

Regular Aspirin Use Y N Dosage & Frequency: _____

NSA (Advil,Motrin,Ibuprofen) Y N Dosage & Frequency: _____

Any Drug Allergy: Y N Drug & Reaction: _____

Latex Allergy Y N Tape Allergy Y N

Family History

Have any blood relatives ever had any of the following:

Abnormal Bleeding:	Y	N	Coronary Surgery:	Y	N	Kidney Disease:	Y	N
Abnormal Clotting:	Y	N	Diabetes:	Y	N	Tuberculosis:	Y	N
Anesthetic Problems:	Y	N	Heart Attack:	Y	N	Other Illness:	Y	N
Cancer:	Y	N	Hypertension:	Y	N			

Please describe questions with "Yes" answer: _____

_____

Personal History

Have you ever had any of the following:

Cancer:	Y	N	Arthritis:	Y	N	Asthma:	Y	N	Acid Reflux:	Y	N
Weight Change:	Y	N	Osteoporosis:	Y	N	Shortness of Breath:	Y	N	Hepatitis:	Y	N
Contact Lenses:	Y	N	High Cholesterol:	Y	N	Abnormal Clotting:	Y	N	Anxiety:	Y	N
Eye Glasses:	Y	N	High Blood Pressure:	Y	N	Abnormal Bleeding:	Y	N	Depression:	Y	N
Dry Eyes:	Y	N	Heart Attack:	Y	N	Blood Thinner Medication:	Y	N	Fainting Spell:	Y	N
Sleep Apnea:	Y	N	Abnormal Heart Rhythm:	Y	N	Anemia:	Y	N	Weakness/Numbness:	Y	N
Snoring:	Y	N	Atrial Fibrillation:	Y	N	Diabetes:	Y	N	Chest Pain:	Y	N
						Insulin Resistance:	Y	N	Thyroid:	Y	N

Please describe questions with "Yes" answer: _____

_____

Have you ever received a Transfusion? Y N If Yes explain: _____

Have you ever been tested for HIV? Y N If Yes, what year _____ Test results: Pos Neg

Previous Surgeries (Type of Procedure & Year): _____

_____

Indicate the Type(s) of anesthesia received in the past. List any complications/reactions you experienced:

Local Anesthesia:	Y	N	Complication/Reaction: _____
General Anesthesia:	Y	N	Complication/Reaction: _____
Spinal/Epidural:	Y	N	Complication/Reaction: _____

Primary Care Physician _____ (Phone):_____ Date Last Seen: _____

For Women Only

Number of Pregnancies: _____ Number of Children: _____ Breast Feed? _____ How Long? _____ Last Period: _____

Location & Date of last mammogram: _____

Authorization for Disclosure of Information

I authorize Dr. Hanemann to disclose complete information concerning his medical findings and treatment of the undersigned, from the initial office visit until the date of the conclusion of such treatment to those individuals who, in Dr. Hanemann's sole determination, are required to receive such information *for the purpose of medical treatment, medical quality assurance and peer review.*

Patient Signature: _____ Date: _____

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Financial Responsibility Agreement

Tobacco or nicotine use in any form is a risk factor known to cause significant wound healing complications after surgical procedures. Examples include, but are not limited to cigarettes, e-cigarettes (vaping), smokeless tobacco products, nicotine patches, and nicotine gum. The specialty of plastic surgery places great emphasis on achieving optimum surgical outcomes by selecting patients who are good candidates for a specific operation. It has been observed and reported after a variety of different plastic surgery procedures that smokers have impaired capacity for wound repair and propensity for skin necrosis. **Outcomes of both cosmetic and reconstructive surgical procedures have been noted to be adversely affected by smoking.**

_____I agree to have nicotine tests prior to surgery and as my surgeon feels necessary postoperatively.

_____ I understand that the morning of my surgery I will be tested for nicotine and should my test be positive I will forfeit my surgery deposit and 10% of the total procedure fee.

_____ I understand I will have to repay the surgery deposit in order to reschedule my surgery in the case my nicotine test is positive.

Signature:_____ Date:_____

Witness:_____ Date:_____

Dijon Plastic Surgery Center
MALIGNANT HYPERTHERMIA SCREENING

Patient Name _____ DOB _____

Please answer the following questions to the best of your knowledge:	YES	NO
Do you have a personal history of Malignant Hyperthermia?		
Has any one of your blood-relatives been diagnosed with Malignant Hyperthermia?		
Has any one of your blood-relatives suffered an unexpected death following general anesthesia?		
Has any one of your blood-relatives suffered an unexpected death following exercise?		
Do you have a personal history (or family history) of a muscle or neuromuscular disorder?		
Have you ever experienced high temperatures following serious exercise?		
Have you ever experienced high temperatures following general anesthesia?		
Do you have a personal history of muscle spasms?		
Have you ever passed very dark or chocolate colored urine?		

Should there be a suspicion you are at a high risk for Malignant Hyperthermia (MH), you may be sent for genetic testing and/or caffeine-halothane contracture testing BEFORE surgery. The physician and anesthesia provider will customize an anesthesia plan that minimizes your risk of exposure to MH triggering agents.

Patient Signature _____ Date _____

Reviewed By _____ Date _____

PATIENT CONSENT TO RECEIVE MAIL AND/OR TELEPHONE MESSAGES

Patient Name: _____
PLEASE PRINT

Do we have your permission to:

Call you/send mail to you at **home?** Y____ N ____

If Yes, may we leave the following information on your **home** answering machine/voice mail:

Appointment information Y____ N ____

Billing Information Y____ N ____

Call you at **work?** Y____ N ____

If Yes, may we leave the following information on your work answering machine/voice mail:

Appointment information Y____ N ____

Billing Information Y____ N ____

I give my permission to share appointment information with the person(s) listed below

Name:_____

Relationship: _____

I gave my permission to share billing information with the person(s) listed below:

Name:_____

Relationship: _____

_____ _____

PATIENT SIGNATURE DATE

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I have been offered the option to receive and review a copy of Michael S. Hanemann, Jr., M.D.'s **Notice of Privacy Practices**.

PATIENT NAME (PLEASE PRINT) _____ DATE _____

PATIENT SIGNATURE _____