MOUNTAIN VIEW COSMETIC SURGERY, LLC
ROBERT T. QUINN II, M.D.
COSMETIC & RECONSTRUCTIVE SURGERY
2450 NE Mary Rose Pl., Suite 200, Bend OR 97701
2301 Clairmont, Klamath Falls OR 97601

PATIENT INFORMATION

Patient's Legal Last Name	First Name	Middle Initial	Sex ☐M ☐F	Birth Date	Age

Mailing Address/Street			

City	State	Zip Code	Cell No.	Telephone No.

Referred by	Family Doctor	Social Security Number	Marital Status ☐M ☐ W ☐ S ☐D

Work Related ☐Y ☐N	Auto Accident ☐Y ☐N	Date of Injury	Are you currently off work due to this injury? ☐Y ☐N	Last Date Worked

Employer name	Occupation	Telephone No.

Parent/Spouse name	Relation	Current Employer	Work Telephone	Home Telephone

PATIENT INSURANCE INFORMATION

Primary Insurance Co.	Group No.	Subscriber ID No.

Name of Person Who Carries Insurance	Date of Birth of Person Who Caries Insurance	Subscriber Social Security #

Insurance Address	Insurance Telephone

SECONDARY INSURANCE CO.

Secondary Insurance Co.	Secondary Group No.	Subscriber ID No.

Name of Person Who Carries Insurance	Date of Birth of Person Who Caries Insurance	Subscriber Social Security #

Insurance Address	Insurance Telephone

IF PATIENT IS UNDER 18 YEARS OLD PLEASE COMPLETE THIS SECTION

Legal Guardian's Full Name	Relation to Patient	Birth Date

Mailing Address if Different From Above	Guardian's Social Security Number

City	State	Zip Code	Telephone

Employee Name	Telephone No.	Position or Title

TELEPHONE CONTACT

Do you have an answering machine? ☐Y ☐N
May we contact you at work? ☐Y ☐N
May we leave medical information on the machine? ☐Y ☐N
May we leave accounting information on the machine? ☐Y ☐N

I hereby authorize Robert T. Quinn , M.D. to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the said doctor all money to which I am entitled for medical and/or surgical expense relative to the services performed from time to time, but not to exceed my indebtedness to said physician and surgeon. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor for all charges for services received.

X _____
Patient's Signature (if patient under 18, guardian please sign)

X _____
Date

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This information is confidential and will not be released without your authorization.

Name_____ **Age**____ **Date**_____
LAST FIRST MIDDLE

Ht_____ **Wt**_____ **Sex:** ☐ **M** ☐ **F** **Primary Physician** _____

Purpose of this consultation: _____

PAST MEDICAL HISTORY: Do you have a significant history of or currently have:

	Yes	No	
Heart	☐	☐	Chest Pains
	☐	☐	Irregular Heart Beat; pacemaker
	☐	☐	High Blood Pressure
	☐	☐	Heart Murmur, leaky valve
Lung	☐	☐	Asthma
	☐	☐	Emphysema
	☐	☐	Other Lung Problems
Cancer	☐	☐	Breast or Any Other _____
Miscellaneous	☐	☐	Tendency to bruise
	☐	☐	Diabetes
	☐	☐	Do you use Aspirin on a regular basis? How much?_____ or Coumadin How much?_____ or Ibuprofen How much?_____
Anesthesia	☐	☐	Problems with prior anesthetics
	☐	☐	Anxiety attacks

Other medical problems or comments:_____

OPERATIONS: Please list all operations you have had.

Operation_____ Year____ Operation_____ Year___
Operation_____ Year____ Operation_____ Year___
Operation_____ Year____ Operation_____ Year___
Operation_____ Year____ Operation_____ Year___

What medications do you take now? (Please do not omit any, as used during/after surgery may interact)

Name of Medication	**Dosage**	**Frequency**	**Purpose**

Do you have any medical allergies? _____

Do you regularly smoke? ☐**Y** ☐**N** **How much per day?** _____

Have you ever smoked? ☐**Y** ☐**N** **Quit when?** _____

WOMEN ONLY

Is there a chance you may be pregnant? ☐Y ☐N How many pregnancies? _____ How many children? _____
Did you breastfeed? ☐Y ☐N How many? _____
Date of last mammogram_____ ☐ Normal ☐Abnormal Specify abnormality_____
Breast cancer: L R Date_____ Mastectomy_____ Surgeon _____
Breast biopsy: L R Date_____ Oncologist_____

EMERGENCY CONTACT _____
PHONE NUMBER _____

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CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize Robert T. Quinn II, M.D. to use and disclose the health and medical information of _____(name of patient) for the purpose of Treatment, Payment and Health Care Operations. *

*Treatment (includes activities performed by a physician, nurse, office staff and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultation between other health care providers. This consent includes treatment provided by any physicians who cover my practice by telephone as the on-call physician).

*Payment (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

*Health Care Operations (includes the necessary administrative and business functions of our office).

You may review Robert T Quinn II, M.D. "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in the CONSENT prior to signing this CONSENT. Please verify that you have received a copy of our Notice by placing your initials here: _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree with your request. If we do agree, we are required to comply with your request* unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that Robert T Quinn II, M.D. Practice has already used or disclosed the information in reliance on this CONSENT.

_____ _____ or
Date (Signature of patient)

_____ _____
Date (Signature of person authorized by law)