Luna Plastic Surgery
Medical History

Office use only BMI: _____ Lose Wt: _____
Problems with Anesthesia: YES NO PONV

Date: _____ **Name:** _____ **DOB:** _____ **Age:** _____ **Height:** _____ **Weight:** _____ ***lbs.***

Marital Status: ***Single Married Divorced Widowed*** **Primary Doctor:** _____ **Office Number:** _____

Do you smoke? Yes ☐ No ☐ If yes, how many years? How many per day?

Are you a previous smoker? Yes ☐ No ☐ If yes, when did you stop smoking?

Do you use illicit drugs? Yes ☐ No ☐ If yes, which one(s)?

Alcohol consumption? Yes ☐ No ☐ If yes, how often? ***Occasional*** **☐** ***Social*** **☐** ***Daily*** **☐**

Are you allergic to any medication? Yes ☐ No ☐ If yes, which meds and reactions:

List of Current medications, including over the counter vitamins and supplements:

Do you take Hormone Replacement? ☐ Yes / ☐ No If so, Which?

List any surgeries you have previously had/been put under general anesthesia:

Does any relative have/had the following conditions? N/A ☐ If so, please list the relation to you:

Breast Cancer ☐ _____ **Melanoma ☐** _____ **High Blood Pressure ☐** _____ **Heart Disease ☐** _____

Heart Stroke ☐ _____ **Lung Disease ☐** _____ **Diabetes ☐** _____ **Kidney Disease ☐** _____

Depression ☐ _____ **Clots in lungs/legs ☐** _____ **Abnormal Bleeding ☐** _____

Medical History
Do you have/had any of the following:

☐ Abnormal Clotting in legs/lungs	☐ Acid Reflux (GERD)	☐ AIDS/HIV	☐ Anemia
☐ Arthritis	☐ Asthma	☐ Bleeding tendency	☐ Blood Infection or sepsis
☐ Cancer	☐ Cholesterol (high or low)	☐ Clotting	☐ Congestive heart failure
☐ COPD	☐ Cystic fibrosis	☐ Depression	☐ Diabetes
☐ Epilepsy/Seizures	☐ GERD	☐ Glaucoma	☐ Heart Disease
☐ Heart Attack	☐ Hepatitis	☐ High Blood Pressure	☐ History of DVT
☐ IBS/ Chron's Disease	☐ Kidney Disease	☐ Liver Disease	☐ Lupus
☐ Mental Disorder	☐ Mitral Valve Prolapse	☐ Massive weight loss/gain	☐ Previous Cancer/ Malignancy
☐ Rheumatic Fever	☐ Seizures	☐ Pneumonia	☐ Sleep Apnea
☐ Spinal Cord Injury	☐ Staph Infection (MRSA or Others)	☐ Stroke	☐ Thyroid Disease
☐ Trauma	☐ Tuberculosis	☐ Ulcers	☐ Varicose Veins

☐ Other:

For Women Only:

Age period began? _____ **Date of last Mammogram?** _____
Are you Pregnant? ☐Yes / ☐ No **Do you do self-breast exams? ☐ Yes / ☐ No**
Do you plan to in the future? ☐ Yes / ☐ No **Current / Past breast lumps? ☐ Yes / ☐ No**
Have you in the past? ☐ Yes / ☐ No **Are you breast feeding? ☐ Yes / ☐ No**

Number of:
Pregnancies: _____ **Natural Births:** _____ **C-Sections:** _____ **Miscarriages/Abortions:** _____

Are you taking Birth Control? ☐ Yes / ☐ No If so, Which method? _____

Luna Plastic Surgery
General Information **Date:**

First name: _____ **Middle:** _____ **Last Name:** _____

Preferred/Nickname: _____ **Date of Birth:** _____ **Gender:** **M** **F**

Reason for your visit: _____

Who may we thank for your visit/ How did you hear about us: _____

Marital Status: ***Single*** ***Married*** ***Other***

Address: _____ **City:** _____

State: _____ **Zip Code:** _____

Phone Number: _____ **Email:** _____

Primary Language: _____ **Primary Care Physician**: _____

EMERGENCY CONTACT

First Name: _____ **Last Name:** _____

Relationship: _____ **Phone number:** _____

PHARMACY INFORMATION

Name: _____

Street Address: _____ **City:** _____

Phone Number: _____

INSURED PARTY

Name: _____ **Date of Birth:** _____ **Gender of Insured:** **M** **F**

Relationship to Insured: _____

INSURANCE INFORMATION

Carrier: _____

Address: _____ **City:** _____ **State/Zip code:** _____

Phone: _____ **Fax:** _____ **Effective date:** _____

Plan Name: _____ **Plane Type:** _____

ID Number: _____ **Group Number:** _____

EMPLOYMENT

Please circle all that apply: ***Full Time*** ***Part Time*** ***Full Time Student*** ***Part Time Student*** ***Retired*** ***Other***

Occupation: _____

Company/School: _____

Address: _____

City, State, Zip: _____

Please note we will make a copy of your driver's license or state issued ID for your record.

Luna Plastic Surgery
Financial Policy

Insurance Patients:

- I agree to furnish Luna Plastic Surgery, PC with a copy of my current health insurance card(s). I also agree to provide an explanation of benefits and/or claim form(s) from my insurance company, when applicable.
- I authorize release of medical information necessary to process my insurance claim and I assign insurance benefits to Luna Plastic Surgery, PC for services provided to me by Dr. Patricia Yugueros.
- I understand that co-pays are due at the time, as required by my insurance company.
- I agree that I am responsible for the balances applied to my account that are not covered by my health insurance plan.
- In the event that my account is turned over to an attorney or collections agency to obtain payment, then I shall be responsible for the attorney's fee, court costs, and any other costs incurred in the collection agency. A copy of my signature shall have the same force and effect as the original.
- I understand that Luna Plastic Surgery, PC will bill my health insurance company and will refund any overpayment on my account to the appropriate party (i.e., insurance company, patient)
- I understand that Luna Plastic Surgery, PC allows 30 days for the processing of my claim by the insurance company. In the event the practice does not receive reimbursement within 45 days, they will contact my insurance company regarding the claim; I will be notified if they do not receive a response.
- I will notify an insurance specialist at the practice if I am aware of a payment delay by my insurance company. It is my understanding the insurance specialist at the practice will provide me with assistance in resolving the claim.
- Any co-insurance, deductible, out of pocket and co-pay amounts will be my responsibility. Any balance left after your insurance has paid must be remitted within 30 days or each month an interest charge will be applied to your account of $10.00 or 10% whichever is greater. In the event I am unable to pay my responsibility in full, I will contact the insurance specialist to discuss financial arrangements.
- I have read, understand, and agree to the insurance assignment and financial policies stated above. I also agree that I have had an opportunity to discuss any questions or concerns regarding the above with the insurance specialist at the practice.
- I understand that my account will be charged $40 when a check I present for payment is returned and marked "non-sufficient funds" (NSF). Returned checks over $500 will be assessed a fee of 5% of the amount of the check.

Self-pay Patients:

- If you plan to pay privately for your services, please be advised that it is the policy of Luna Plastic Surgery, PC to collect payment in full at the time of service. If you are unable to make payment in full at the time of service, your appointment/surgery will be rescheduled for a more convenient time.

Motor Vehicle Accidents (MVA)/Third Party Liability:

- We will require all claim details (claim number, contact information, bill address) at the time of your appointment; otherwise, we will require payment in full for services rendered for each patient being treated for a MVA/other accident-related injury. We will file claim(s) with motor vehicle or third-party insurance company you designate, provided we receive all necessary information with which to bill. If the claims are denied, or a protracted lawsuit is involved, the patient is responsible for paying the account balance in full. We will bill your private health insurance for balances left after your personal injury protection (PIP) is exhausted.

Form Fees:

- Forms and letters requested by our patient will be assessed a fee as listed below. This list is not meant to be all inclusive but is merely representative of the items that may incur a charge. This fee covers our administrative expenses related to physician/staff time, photocopying, mailing, etc.
    - Disability Forms: $20 each
    - Letters of Medical Necessity: $30 each
    - Medical Records pages 1-35/0.75¢ per page or more than 35 pages/ 0.20¢ per page plus postage

I acknowledge that I have received a copy of this financial policy. I agree to read this document and comply with the terms set forth for services rendered by Luna Plastic Surgery, PC.

_____ _____

Patient Signature (Guarantor) Date