LOHNER PLASTIC SURGERY

Ronald A. Lohner, M.D.

Patient Information

Today's Date_____

Legal Name (Last, First, Initial) _____SS# (necessary for surgery) _____

Date of Birth_____ Age _____ Male_____ Female_____

Marital Status: Married _____Single_____ Divorced_____ Widowed_____

Street Address_____ Apt #_____

City, State & Zip Code_____

Cell Phone_____ Home Phone_____

Email Address_____ Fax _____

*You will receive text message reminders for your appointments.

Patient's Employer_____ Work Phone_____

Reason for Today's Visit _____

Referring Physician & Address_____

City, State & Zip _____ Office Phone_____

Family Physician & Address _____

City, State & Zip _____ Office Phone _____

Emergency Contact _____ Cell Phone_____

Relationship_____ Address _____

919 Conestoga Road
Building One, Suite 200
Rosemont, PA 19010

610-519-0600 Phone
610-519-1238 Fax
www.lohnerplasticsurgery.com

Lohner Plastic Surgery

Last Name_____ First Name_____ Date_____

General Health (Please Circle One) GOOD FAIR POOR

Please Explain _____

Date of most recent physical exam _____Chest X-Ray _____EKG _____

Height _____Weight _____ Number of term pregnancies _____

Previous Surgeries (Operation, Date, Surgeon & Facility)

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS (Please Circle One) YES NO

If yes, please list with reaction

_____

Please LIST ALL MEDICATIONS you are currently taking (including prescription and non-prescription drugs including: aspirin, hormones, vitamins, herbs, birth control, recreations) include dosage:

_____

_____

Do you have an Internal Electronic Device (IED)? YES NO

If yes, Company/Manufacturer_____ Device _____

Have you ever been treated for any of the following? (please circle all that apply)

CANCER (specify) _____ HEART DISEASE/HIGH BLOOD PRESSURE

ASTHMA/LUNG DISEASE DIABETES SLEEP APNEA SEIZURES/STROKE

CAD CHF CARDIAC ARRHYTHMIA REFLUX RENAL INSUFFICIENCY

SKIN CONDITIONS (ECZEMA, PSORIASIS, SCLERODERMATITIS)

VASCULAR/CIRCULATORY/BLOOD BLEEDINGDISRODERS

Please list any other medical conditions you have or have had in the past _____

_____

What is your DAILY consumption of the following: Coffee/Tea_____ Alcohol_____ Tobacco _____

Are you allergic/sensitive to any surgical materials (i.e. adhesive tape, suture, iodine prep, etc.)?

YES NO If so, please list_____

Are you currently pregnant? YES NO

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AUTHORIZATION FINANCIAL RESPONSIBILTY

I authorize the release of my medical records to my insurance carrier in the event copies of these records are requested by my insurance carrier(s)

Name_____ Date_____

I understand that my insurance policy states I will have a co-pay and/or deductible related to my office visit(s) or my surgery(ies) with Dr. Lohner. I understand I am legally responsible for any and all co-pays and deductibles.

Name_____Date_____

I request that you file claims with my insurance carrier(s) for testing, treatment and procedures performed in the event these are not covered, excluded or denied by my insurance carrier(s).

Name_____ Date_____

I acknowledge and accept financial responsibility for all testing, treatment and procedures performed in the event these are not covered, excluded or denied by my insurance carrier(s).

Name_____ Date _____

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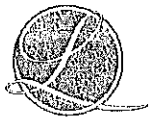

LOHNER
PLASTIC SURGERY
919 Conestoga Road, Bldg 1, Ste 200
Bryn Mawr, PA 19010

Patient Record of Disclosures

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provides the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individuals home.

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

☐ Telephone_____
- ☐ O.K. to leave detailed message
- ☐ Leave message with call back number only

☐ Work Telephone_____
- ☐ O.K. to leave detailed message
- ☐ Leave message with call back number only

☐ Written Communication
- ☐ O.K. to mail to my home address

☐ Other_____
_____

I authorize the practice to disclose my PHI to those individuals listed below:

Name	Relation	Contact Number

The information that can be disclosed to the above individuals includes:

☐All PHL

☐Only information relating to appointments and payments

☐Other: _____

With the option to exclude:

☐None

☐HIV/STD information

☐Any health diseases

☐Other: _____

_____ _____
Patient Signature Date

_____ _____
Print Name Date of Birth

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Privacy Practices Acknowledgement

Acknowledgement Form:

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____Birthdate_____

Signature_____

Today's Date_____

Annual acknowledgement:

Sign_____Date_____

Sign_____Date_____

Sign_____Date_____

Sign_____Date_____

Sign_____Date_____

Sign_____Date_____

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PATIENT PHOTO RELEASE CONSENT FORM

NAME_____

ADDRESS_____

I consent to the taking of photographs by Dr. Lohner or his designee of me or parts of my body in connection with the Plastic Surgery procedure(s) to be performed by Dr. Lohner.

I provide this authorization as a voluntary contribution in the interests of Public Education. I understand that such photographs can be used in any print, visual or electronic media, specifically including but not limited to, medical journals and textbooks, advertisements for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive from Dr. Lohner.

I understand that I have the right to inspect and copy the information I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it will not have any effect on any actions taken prior to my revocation. If I do revoke this authorization, it will expire ten years from the date written below.

I release and discharge Dr. Lohner, and all parties action under their license and authority from all rights that I may have in photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____

Signature Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of _____, a minor. I am authorized to sign this authorization on his/her behalf, and I give this authorization as a voluntary contribution in the interest in Public Education.

_____ _____

Signature Date