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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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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Insurance Information & Authorization

(Please Print Legibly & Sign)

Patient's Name _____
First Middle Last

Primary Insurance Company _____

Policyholder's Information:

Name _____ Birthdate ___/___/___

Employer _____ Relationship to Patient _____

Does this insurance required a referral? ☐ Yes ☐ No Copay Amount $ _____

Secondary Insurance Company _____

Policyholder's Information:

Name _____ Birthdate ___/___/___

Employer _____ Relationship to Patient _____

Does this insurance required a referral? ☐ Yes ☐ No Copay Amount $ _____

Is this visit due to any type of accident? ☐ No ☐ Yes: Date of Accident _____

Type of Accident ☐ Auto: State? _____ ☐ Work Related ☐ Other: _____

All Insurance Patients – Signature on File

I request that payment of authorized benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services.

Beneficiary Signature _____ Date _____

Medicare Patients Only – Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____