J. SMYTHE RICH, III, M.D.
Facial Plastic & Reconstructive Surgery

PATIENT INFORMATION

******Please submit your Drivers License and Insurance Card with this form******

Patient Name:____Age:_____________Date:__________________

Email Address:____

SSN:____________________________________ Date of Birth:_______________________ SEX: Male / Female

Marital Status:__________________________Spouse Name:____

Primary Care Physician: ____*Phone:*______________________________

Patient Address:__________________________________City:__________________State:_______Zip:______________

Home Phone:____ Work Phone:_________________________________

Cell Phone:____ Carrier (for Appt. Reminder Texts)________________________

Emergency Contact:________________________________Relationship:________________Phone:______________________

How did you hear about us?

[ ] Your Doctor _______________________________ [ ] Friend________________________________

[ ] Advertisement______________________________ [ ] Internet_______________________________

[ ] PhoneBook/Other (Please Specify)____

1711 Richland Street Columbia, South Carolina 29201
P. 803.799.3223 (FACE) F. 803.933.9460 www.scfaces.com

CERTIFIED
American Board of Facial Plastic and Reconstructive Surgery | American Board of Otolaryngology/Head and Neck Surgery
Practice limited to reconstructive and cosmetic facial plastic surgery, functional and cosmetic nasal/sinus surgery

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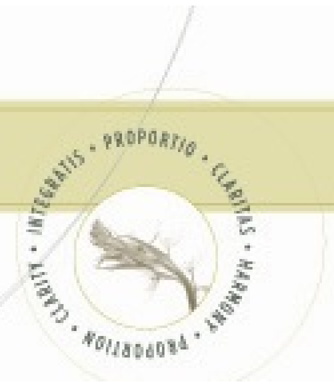

Medical History

Name:___________________________________Date of Birth:_________________Date:________________

Reason for visit?____

Who is your family doctor?__________________________________Phone Number__________________________

When was your last physical examination?____

Have you had any of these procedures performed?

[ ] Filler [ ] Botox [ ] Rhinoplasty (Nose) [ ] Chin [ ] Face or Neck Lift [ ] Eyelids [ ] Removal of cysts, warts, moles, etc

[ ] Chemical Peel [ ] Resurfacing [ ] Scar Revision [ ] Protruding Ears [ ] Liposuction [ ] Other______________________

Check any of the following that you have experienced:

[ ] Asthma	[ ] Arthritis	[ ] Venereal Disease	[ ] Other Blood Problems
[ ] Hay Fever	[ ] Arthritis Therapy	[ ] AIDS	[ ] Alcohol Abuse Therapy
[ ] Nasal Allergies	[ ] Steroid Therapy	[ ] Frequent Headache	[ ] Bouts of Depression
[ ] Vision Problems	[ ] Poor Circulation	[ ] Excess Scarring	[ ] Bouts of Unhappiness
[ ] Thyroid Therapy	[ ] Kidney Trouble	[ ] Dizziness	[ ] Nervous Breakdown
[ ] Frequent Chest Pain	[ ] Bladder Trouble	[ ] Convulsions	[ ] Psychiatric Therapy
[ ] Lung Trouble	[ ] Skin Infection	[ ] Paralysis	[ ] Stomach Ulcers
[ ] Heart Trouble	[ ] Skin Irritation	[ ] Hormone Therapy	[ ] Other Stomach Trouble
[ ] High Blood Pressure	[ ] Rashes	[ ] Anemia	[ ] Liver Trouble
[ ] Diabetes	[ ] Fever Blisters	[ ] Profuse Bleeding	[ ] Gall Bladder Trouble
[ ] Yellow Jaundice	[ ] Genital Herpes	[ ] Excess Bruising	[ ] Drug Abuse Therapy

Yes No Are you now taking **any** drugs or medications? What and how often:_____________________________

____

Yes No Are you allergic to **any** medications, creams, tape, make-up, etc?__________________________________

Yes No Do you smoke Cigarettes? How many a day?____

Yes No Do you drink more than 6 cups of coffee a day?

Yes No Do you usually drink two or more alcoholic drinks a day?

Yes No Do you have any other medical problems that have not been covered?______________________________

____

Yes No Do you accept the fact that every medical and surgical treatment is associated with risks?

Yes No Do you give consent and authorize the recommended diagnostic, medical, surgical, anesthetic, and other diagnostic services that the clinic deems beneficial while you are under their care?

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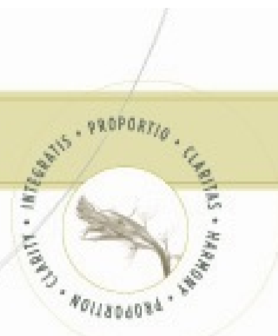

FINANCIAL POLICY & HIPAA CONSENT

We will file *medically necessary* services to your *in-network* insurance carrier as a courtesy. It is your responsibility to ensure that your insurance carrier processes your claim in a timely manner and/or to resolve any discrepancies concerning payment with your insurance carrier. All charges must be paid in full within 60 days of occurance. Any balance remaining after 60 days may be subject to collection activity and associated collection fees up to 50% of the overdue balance *plus* up to $25 in adminisrative fees. Missed appointment and excesssive cancellations or re-scheduled appointments will result in a $50 fee for each appointment, and a $150 fee for procedures. All returned checks will be subject to a $30 Returned Check fee. Payment is accepted in the form of: Cash, Check, Visa, MasterCard, Discover, and/or Gift Certificates issued by our office.

Payment is expected in full at the time of service.

Insurance Information: *(Insurance Card Required)*

Insurance Carrier:____ID#:_________________________________

Policyholder Name:____Policyholder DOB:______________________

Policyholder SSN:____________________________________ Relationship to Patient:___________________________

Policyholder Address:____Phone:_______________________

Employer:____ Employer Phone:________________________

Employment Status: [ ] Full Time [ ] Part Time [ ] Retired [ ] Self Employed [ ] Student [ ] Military [ ] Unemployed

Protected Health Information will not be released to any party except as authorized by law, or with written or verbal consent from the patient. I authorize the release of any medical information by J. Smythe Rich, MD, PA as necessary:

For the purposes of diagnosis and treatment of any medical condition.

To obtain payment for services rendered by J. Smythe Rich, MD, PA or members of his staff.

To submit medical claims and request payment of medical benefits to J. Smythe Rich, MD, PA, for services described on the claim form.

To the following individual(s):____

I have been offered and read the privacy policy and financial policy and agree to the terms herein. This notice has been issued and is effective on the date signed. I understand that this authorization or a photo copy shall be valid.

____ ____________________

Signature Date

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