SOMERSET PLASTIC SURGERY

MICHAEL J. BUSUITO, MD [ ] ANDREW K. GAVAGAN, MD [ ] PRAVIN P. PURI, MD [✓]

Print Legibly

Patient's Name: Last:_____ First:_____ MI:_____

Address _____
Street & Apt # City State Zip

Home #: _____[ ] Cell #: _____[ ] Other # _____[ ] Please ☑ preferred #

E-mail _____ Driver's License #: _____ State _____

Age _____ Birthdate____/____/_____ SS#: _____-_____-_____ Sex ☐ Female ☐ Male

☐ Single ☐ Married Spouse_____ ☐ Other _____

RACE: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Hispanic ☐ OTHER _____ LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ Other_____
Race is a federal requirement mandated by CMS-Centers for Medicare & Medicaid Services – Appropriate Box(s) must be marked

Emergency Contact _____ Relationship to Pt: _____
(Not in your household)
Phone # _____ Address: _____

Patient's Employer _____ Occupation_____

Work Phone _____Ext: _____ Is it okay to call you at work? ☐ No ☐ Yes

Spouses Employer _____ Occupation_____

Referred By: _____

Phone # _____ Address: _____

Primary Care Physician _____

Phone # _____ Address: _____

Primary Health Insurance Company:_____

Policy #: _____Group #: _____ Copay? ☐ No ☐ Yes $_____ Referral Required? ☐ No ☐ Yes

Subscriber: Name: _____ DOB: ____/____/____ Subscriber SS#: _____-_____-_____

Secondary Health Insurance Company _____

Policy #: _____Group #: _____ Copay? ☐ No ☐ Yes $_____ Referral Required? ☐ No ☐ Yes

Subscriber: Name: _____ DOB: ____/____/____ Subscriber SS#: _____-_____-_____

Authorization to pay benefits to physician and release of medical information: I hereby authorize payment directly to Pravi Puri, M.D. of any Surgical and/or medical benefits otherwise payable to me for his services. I hereby authorize Dr. Puri to release any medical information for payment on my insurance claim. I understand I am responsible for payment of all copays and deductible as required by my insurance company.

Signature _____ **Date** _____

SOMERSET PLASTIC SURGERY
HEALTH HISTORY FORM

MICHAEL J. BUSUITO, MD | | ANDREW K. GAVAGAN, MD | | PRAVIN P. PURI, MD [✓]

NAME _____ ☐ Female ☐ Male Age_____
Last First MI

DATE OF BIRTH _____/_____/_____ Height _____ Weight_____

Reason for your visit today _____

MEDICAL CONDITIONS: ✓ appropriate boxes below

☐ No Past Medical History
☐ AIDS
☐ Alcoholism
☐ Anemia
☐ Anesthesia Problems
☐ Autoimmune Disorder
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Breast Cancer
☐ Cancer _____
☐ Chemo Therapy
☐ Chest Pain / Tightness
☐ Depression / Anxiety
☐ Diabetes
☐ Heart Disease
☐ Hepatitis
☐ Heart Murmur
☐ Healing Problems _____
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV Positive
☐ Kidney Disease
☐ Liver Disease
☐ Pacemaker
☐ Post Radiation Therapy
☐ Psychiatric Care
☐ Skin Cancer
☐ Stroke
☐ Substance Abuse
☐ Thyroid Problem
☐ Tuberculosis
☐ Transfusion _____

☐ Other _____

FEMALES ONLY:
☐ Fibrocystic Breast
☐ BRCA Gene Positive
☐ Menopause
☐ Ovarian Cancer
Plan Becoming Pregnant?
☐ Yes ☐ No
# of Pregnancies _____
Live births _____
Ages of Children _____
Currently Pregnant
☐ Yes ☐ No
Last Mammogram
Normal ☐ Yes ☐ No
Date _____

MEDICATIONS: Attach Sheet if more room is needed
ARE YOU TAKING ASPIRIN ☐ Yes ☐ No Dose _____

DRUG NAME	DOSE	FREQUENCY

Pharmacy _____ Phone _____
Address _____

ALLERGIES : LATEX ☐ Yes ☐ No
Please List All Medication / Substance Allergies

SURGICAL HISTORY List any surgeries / hospitalizations

Description	Year

FAMILY HISTORY ✓ if applicable
☐ Breast Cancer – Who _____
☐ Diabetes
☐ Heart Disease / Stroke
☐ High Blood Pressure
☐ Hemophilia
☐ Malignant Hypothermia / Hyperthermia
☐ Ovarian Cancer
☐ Skin Cancer
☐ Abnormal Bleeding; Abnormal Clotting
☐ Other _____

SOCIAL HISTORY ✓ if applicable
Smoking ☐ Yes ☐ No # of Packs daily_____ # years smoked _____
Former Smoker ☐ Yes ☐ No When did you quit? _____ # of Packs daily_____ # years smoked _____
Alcohol ☐ Yes ☐ No # drinks weekly _____ Substance Abuse ☐ Yes ☐ No Caffeine ☐ Yes ☐ No

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Busuito responsible for any omissions / errors I have made in completing this form. This information is confidential and will not be released without consent.

Signature_____Date_____Reviewed by_____Date_____

PERSONAL MEDICATION RECORD

Name: _____ **Date of Birth:** _____
Allergies: _____
Physician: _____ **Physician Phone#:** _____
Pharmacy: _____ **Pharmacy Phone#:** _____

Name of Medication (Prescription, over-the-counter, eye drops, supplements Patches, herbals, inhalers, implanted pumps)	**Dose of Medication** (Example: one 20 mg. tablet)	**When is Medication Taken?** (Examples: three times a day at bedtime)

Patient Signature: _____ Date: _____

(For Office Use Only)

REVIEWED DATE:	**BY:**	**LIST NEW OR CHANGED MEDICATIONS**

KEEP A COMPLETED & UP-TO-DATE CARD WITH YOU AT ALL TIMES

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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided 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 Individual's home.

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

- ☐ Home Telephone _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only
- ☐ Work Telephone
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only
- ☐ Written Communication
- ☐ OK to mail to my home address
- ☐ OK to mail to my work/office
- ☐ OK to fax to this number _____

_____ Patient Signature

_____ Date

_____ Print Name

_____ Date of Birth

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO (treatment, payment or healthcare operations) may be permitted without prior consent in an emergency

_____ Patient Signature

Date	Disclosed to add/fax	(1)	Description/Purpose	By Whom	(2)	(3)

(1) Check if authorized (2) Type: T=Treatment P=Payment O=Healthcare Operations

Somerset Plastic Surgery PLLC
1080 Kirts Blvd Suite # 700
Troy, Michigan, 48084
P (248) 362-2300
F (248) 362-5272

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME _____ **DATE** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that ISomerset Plastic Surgery PLLC may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Somerset Plastic Surgery PLLC has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Somerset Plastic Surgery PLLC will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Somerserset Plastic Surgery PLLC to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Somerset Plastic Surgery PLLC has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

Relationship to Patient if signed by another party _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Somerset Plastic Surgery PLLC, 1080 Kirts Blvd., Suite 700, Troy, MI 48084.

FORM Us

Somerset Plastic Surgery, P.L.L.C.

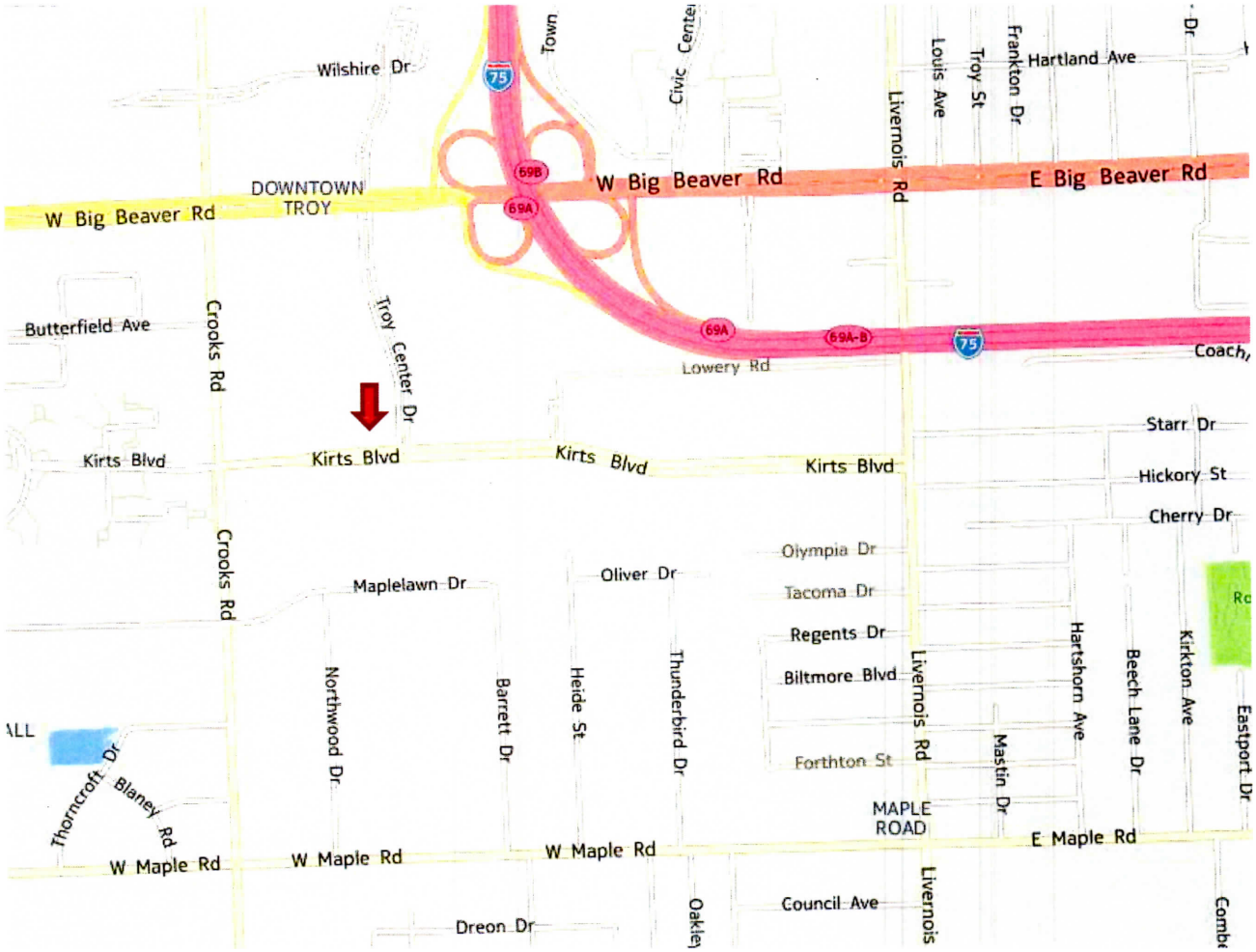
Drs. Busuito, Gavagan & Puri

Plastic & Reconstructive Surgery

1080 Kirts Blvd., Suite 700

Troy, MI 48084

Office (248) 362-2300 Fax (248) 362-5272



DIRECTIONS:

From I-75
Exit 69 – Big Beaver Road – West to Crooks
Turn Left on Crooks (South)
½ Mile to Kirts Blvd. – turn left on Kirts Blvd
¼ Mile down Kirts Blvd. to Troy Center Drive
Turn Left on Troy Center Drive

Our building is a single story red brick office building that sits on the corner of Kirts and Troy Center Drive, across from the Candlewood Suites Hotel. Park in the lot off of the North side of the building, Suite 700.