SAUNDERS PLASTIC SURGERY

PATIENT REGISTRATION

PLEASE ANSWER ALL QUESTIONS IN THIS SECTION DATE:_____

Patient's Name: _____ Home Phone:_____

Parent's Name (minors only): _____ Cell phone:_____

Social Security Number:_____-_____-_____ Address:_____

Date of Birth:_____ Sex: (circle) M F _____

Marital Status: (circle) Single Married Divorced Widowed City, State, Zip: _____

Drug Allergies:_____ _____

_____ Email: _____

Medications Currently Taking: _____ Employer: _____

_____ Employer's Address: _____

_____ _____

Family Doctor: _____ Employer's Phone:_____

Referring Physician:_____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Relationship to Emergency Contact: _____

Reason for Visit: _____

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HEALTH INSURANCE INFORMATION

Insurance Company:_____ Identification #:_____

Subscriber's Name & D.O.B.: _____

Subscriber's Social Security #:_____-_____-_____

Do you have a referral from your primary care physician for today's visit? (circle) YES NO

Where did you hear about us?

Circle: Physician Referral Friend Delaware Today Former Patient

Seminar, Date: _____ Website:_____ Other:_____

NAME: _____ DATE: _____

PERSONAL PAST HISTORY - Have you ever had the following: (please check Yes or No)

	Yes	No		Yes	No		Yes	No
Abnormal Bleeding	___	___	Asthma	___	___	Hypertension	___	___
Abnormal Clotting	___	___	Diabetes	___	___	Sleep Apnea	___	___
Acid Regurgitation	___	___	Fainting Spell	___	___	Snoring	___	___
Anemia	___	___	Heart Attack	___	___	Weight Change past 12 mos	___	___
Angina	___	___	Hepatitis	___	___	Other Serious Illness	___	___
Staph Infection	___	___	M.R.S.A.	___	___	Latex Allergies	___	___

Please describe Other Serious Illness and any questions with "Yes" answer: _____

_____

Have you ever received a transfusion? Yes _____ No _____ If yes, what year? _____

Have you ever been tested for HIV? Yes ___ No ___ If yes, what year? _____ Test Results: __Positive __Negative

Do you wear any of the following:

Contact Lenses? ___Yes ___No Eye Glasses? ___Yes ___No Hearing Aid? ___Yes ___No Dentures ___Yes ___No

Previous Surgery (Please provide year & type of procedure): _____

_____

Indicate the type(s) of anesthesia received in the past, list any complications or reactions you experienced:

____ Local Anesthesia - complications / reactions _____

____ General Anesthesia - complications / reactions _____

____ Monitored Anesthesia care - complications / reactions _____

____ Spinal / Epidural - complications / reactions _____

Date last seen by Primary Care Physician: _____ Primary Care Physician Name: _____

Primary Care Physician Address: _____ Phone #: ( ) _____

Have you ever been seen by a cardiologist? ___Yes ___No If yes, Cardiologist Name: _____

Cardiologist Phone # ( ) _____

SOCIAL HISTORY

Age: _____ Sex: ____M ____F Married: ____Y ____N Occupation: _____

Responsible adult available to assist during recovery period: ___Y ___N Relationship: _____

Smoke: ____Y ____N Amount: _____ Coffee/Tea/Cola: ___Y ___N Amount: _____

Alcohol: ____Y ____N Amount: _____ Daily Exercise: ___Y ___N Amount: _____

FAMILY HISTORY - Have any blood relatives ever had the following problems:

	Yes	No		Yes	No		Yes	No
Abnormal Bleeding	___	___	Coronary Surgery	___	___	Kidney Disease	___	___
Abnormal Clotting	___	___	Diabetes	___	___	Tuberculosis	___	___
Anesthetic Problems	___	___	Heart Attack	___	___	Cancer	___	___
Hypertension	___	___	Stroke	___	___	Other Serious Illness	___	___

Please describe questions with a "Yes" answer: _____

_____

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REVIEW OF SYSTEMS ---- BELOW TO BE COMPLETED BY PHYSICIAN ONLY

	Yes	No		Yes	No		Yes	No
Loose Dental Devices	___	___	Recent Up Resp Infection	___	___	Vomiting	___	___
Neck Mobility Prob.	___	___	Normal Menstrual Cycle	___	___	Difficulty Voiding	___	___
Short Neck	___	___	Stroke	___	___	Seizure	___	___
Cough	___	___	Chest Pain	___	___	Current Pregnancy	___	___
Shortness of Breath	___	___	Irregular Heart Beat	___	___	Black Out	___	___
Obesity	___	___	Height _____	Weight _____		Hosp _____	ASF ____	

Comments: _____

_____

MONETARY AND CANCELLATION POLICIES

Dr. Saunders strives to give all his patients the highest quality care in the office and in the operating room. Missed appointments and cancelled appointments cost time and money. Please be courteous and notify the office of your change of plans. You will be billed for missed appointments and cancellations within 48 hours of the appointment.

1. Cancelled office visits within 48 hours of the appointment and missed appointments ("no shows") have a $100.00 expense billed to you as this does not allow the office the opportunity to offer the appointment time to another patient.

2. Payment for cosmetic office procedures such as: Botox, Fillers, Sclero-Therapy, Laser Treatments are due upon scheduling. Cancellations within one week of the procedure will lead to a $200.00 charge because of lost time and materials purchased in anticipation of your procedure.

SCHEDULING SURGERY

Many patients are trying to schedule surgery and the office is trying to help you and all others interested in surgery dates, which will best accommodate all parties' schedules. Schedules are done far in advance and rescheduling/cancellations can cause lost time. Please carefully choose your surgery date.

1. A **NON-REFUNDABLE** deposit of $500.00 is required to schedule surgery. This is applied towards the cost of the procedure. Your $100.00 Consult Fee is included in the $500.00 Non-Refundable deposit.

2. Full payment for the remaining balance is due **ONE MONTH PRIOR** to your surgery date or at time of scheduling if your procedure is scheduled within one month.

3. Cancellation of surgery:

- 30 day or more notice-Full refund except **non-refundable deposit.**
- 15-29 days- 50% refund.
- 14 business days or less- No refund.
- **Non-refundable deposit for surgery may not be used for Med-Spa services or products.**

Patient Signature _____ Date _____

Witness Signature _____ Date_____

CONSENT FOR PHOTOGRAPHS

Christopher J. Saunders, M.D., F.A.C.S., P.A.

Brandywine Surgery Center
1224 Baltimore Pike Suite 100
Chadds Ford, PA 19317
(610) 459-1559

Lombardy Medical Center
410 Foulk Road Suite 203
Wilmington, DE 19803
(302) 652-3331

Date: _____

Patient's Name: _____

In connection with the medical services I am receiving from Dr. Christopher J. Saunders, I consent that photographs may be taken of me or parts of my body, under the following conditions:

1. **The photographs may be taken with the consent of my physician and under such conditions and at such times as may be approved by him.**
2. **The photographs shall be taken by my physician or a photographer approved by my physician.**
3. **The photographs shall be used for medical records, and if in the judgement of my physician, medical research, education, or science will benefit by their use, such photographs and information relating to my case may be published and republished either separately or in connection with each other, in professional journals or medical books, or used for any other purposes which may deem proper in that interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use, I shall not be identified by name.**
4. **The above-mentioned photographs may be modified or retouched in any way that my physician, in his direction, may consider desirable.**

Patient signature: _____

(Or if minor, parents signature above)

NOTICE OF PRIVACY PRACTICES

QUESTIONS AND COMPLAINTS:

If you have any questions about this notice, please contact:

Christopher J. Saunders, M.D., F.A.C.S., P.A.
Attention: Practice Manager
Brandywine Surgery Center
1224 Baltimore Pike, Suite 100
Chadds Ford, PA 19317
(610) 459-1559

If you think we have violated your privacy rights, contact the person named above. You may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

ACKNOWLEDGEMENT FORM

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

NAME: _____

SIGNATURE: _____

DATE: _____

Brandywine Surgery Center

Patient notification and Disclosure of Physician Ownership

This document serves as a formal notice to you that your physician, Christopher J. Saunders, M.D., F.A.C.S., P.A., is an investor/owner of the Brandywine Surgery Center. By signing below you acknowledge that you have received this notice and that if you choose to have surgery and it is at the Brandywine Surgery Center, you understand that your physician is an investor/owner. You further acknowledge that you understand that it is your right to ask your physician for an alternative service location should you not choose to use the Brandywine Surgery Center.

F you have any questions, comments or concerns regarding this notification and disclosure, please speak to your physician or ask to speak to a member of the Brandywine Surgery Center staff by calling: 610-459-1559.

Thank you for choosing the Brandywine Surgery Center!

By signing this notice, I acknowledge that this has been received prior to my date of surgery.

_____

Printed Name of Patient

_____ _____

Signature of Patient or Legally Authorized Representative **Date**

_____

Printed Name of Witness

_____ _____

Signature of Witness **Date**

For Office Use Only

MD Name: Christopher J. Saunders, M.D., F.A.C.S., P.A.

Witness is:

☐ Spouse ☐ Family Member ☐ Office Staff ☐ Other _____