The Center for Cosmetic & Plastic Surgery
Aesthetic, Plastic, and Reconstructive Surgery
1353 East McAndrews Rd. Medford, OR 97504
Telephone (541) 770-6776

Robert M. Jensen, M.D., F.A.C.S. **Amy B. Jensen, N.P.**

Patient Information

Date: <Appointment.Date> ☐ Male ☐ Female

Patient Name: <PersonalInfo.FullName> **DOB:** <PersonalInfo.DOB>

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated **Age:** <PersonalInfo.Age>

Race: <PersonalInfo.Race> **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic **SSN:** <PersonalInfo.SSN>

Address: <PresentAddress.Address> **City:** <PresentAddress.City> **State:** <PresentAddress.State> **Zip:** <PresentAddress.Zip>

Occupation: _____ **Employer:** _____

Home Phone: <PresentAddress.HomePhone> **Cell:** <PresentAddress.CellPhone> **Work:** <EmployerAddress.Phone>

Email: <PersonalInfo.EmailAddress> **Primary Physician:** <ReferringProvider.PrimaryCareProvider>

Permission to share information with primary care physician? ☐ **Yes** ☐ **No**

How did you hear about us?

☐ RealSelf.com ☐ Doctor Referral: _____

☐ jensenmd.com ☐ Friend or Family: _____

☐ Google ☐ Patient Referral: _____

☐ Billboard ☐ Other: _____

Insurance Information

Insurance Carrier: <PrimaryInsurance.InsuranceCompany> **Policy:** <PrimaryInsurance.PolicyNumber> **Group:** <PrimaryInsurance.GroupNumber>

Subscriber Name: _____ **DOB:** _____

Emergency Contact

Name: _____ **Relationship to patient:** _____

Cell: _____ **Home:** _____ May we share your medical information with this person? ☐ Yes ☐ No

Please list any other people we can share info. with: _____

_____

Jensen
CENTER for COSMETIC & PLASTIC SURGERY

Do you have an advanced directive? ☐ No ☐ Yes: _____

Reason for Visit: _____

Medical History/ Review of Systems

Check the box if you have experienced any of these symptoms or conditions.

Palpitations	☐	Bleeding Tendency	☐	Heart Problems	☐
Cancer	☐	Asthma/ Emphysema	☐	Abnormal EKG	☐
Chemo	☐	Lung Disease	☐	Pacemaker/ Defib	☐
Radiation	☐	Tuberculosis	☐	Chest Pain	☐
Sleep Apnea	☐	Coughing up Blood	☐	Paralysis or Stroke	☐
Liver Disease	☐	HIV/ Hepatitis	☐	Thyroid Problems	☐
MRSA	☐	Psychiatric Condition	☐	Frequent Headaches	☐
Lung Disease	☐	Seizures/ Epilepsy	☐	Kidney Disease	☐
Dizziness	☐	Blood Clots You or Family	☐	Edema/ Ankle Swelling	☐

Functional Status: ☐ Independent ☐ Partially Independent ☐ Totally Dependent

Do you use steroids (prednisone, cortisone, etc.) for chronic condition?	☐ Yes	☐ No
Have you ever been diagnosed with a condition called Ascites?	☐ Yes	☐ No
Do you have Diabetes?	☐ Yes	☐ No
Do you have high blood pressure that is not treated with medications?	☐ Yes	☐ No
Do you have high blood pressure that you take medication for?	☐ Yes	☐ No
Have you been diagnosed with congestive heart failure?	☐ Yes	☐ No
Do you have any shortness of breath with physical exertion?	☐ Yes	☐ No
Have you smoked in the last year?	☐ Yes	☐ No
Do you have a history of COPD (Chronic Obstructive Pulmonary Disease)?	☐ Yes	☐ No
If yes, is it severe?	☐ Yes	☐ No
Have you been diagnosed with Renal Failure (Kidney Failure)?	☐ Yes	☐ No
Have you had a mammogram within the past 2 years?	☐ Yes	☐ No
Have you had a flu Shot this year (for the current flu season)?	☐ Yes	☐ No

Previous Surgeries

Year	Type

Allergies/ Sensitivities to Medications

Previous reaction to anesthesia? ☐ Yes ☐ No

Describe: _____

Family history of MH? ☐ Yes ☐ No

Are you allergic to latex? ☐ Yes ☐ No

Are you allergic to medications? ☐ Yes ☐ No

Drug	Reaction

Medications

Please list all prescription and over the counter medications you take. You may attach a list with your name printed on it.

Drug	Dosage

Jensen
CENTER for COSMETIC & PLASTIC SURGERY

I do not take any medication or vitamins. ☐

Family History Significant Health Problems

Father
Mother
Siblings
Children

Do you take aspirin/ Ibuprofen/ Aleve? ☐ Yes ☐ No

Do you take a blood thinner? ☐ Yes ☐ No

Social History

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much?

Do you currently smoke? ☐ Yes ☐ No

Have you smoked in the past? ☐ Yes ☐ No

If yes, when did you quit?

Do you use recreational drugs? ☐ Yes ☐ No

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: **Date:**

Assignment and Release

I, <PersonalInfo.FirstName> <PersonalInfo.LastName>, have insurance coverage and assign directly all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/ Guardian

Date

HIPAA Information and Consent Form

Patient Name: <PersonalInfo.FirstName> <PersonalInfo.LastName>

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the
patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, <PersonalInfo.FirstName> <PersonalInfo.LastName>, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Jensen
CENTER for COSMETIC & PLASTIC SURGERY

Signature: _____ Date: <Appointment.Date>

Consent to Communicate

Patient Name: <PersonalInfo.FirstName> <PersonalInfo.LastName>

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another person	Preferred Contact Method(s)	Best Time to Call
☐ Call Work Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐	
☐ Call Cell Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐	
☐ Call Home Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐	
☐ Send Email			☐	
	☐ Email Appt Reminders	☐ Emal Medical Info	☐ Email Marketing Info	
☐ Send Regular Mail			☐	
Mail to which address: ☐ Home ☐ Other (Please List):				
☐ Send Text Message			☐	
☐ Text Appt Reminders				
☐ Text Marketing Info				

Best Time to Call, Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message.

If it is ok to leave a message with another person, please list them:

Name	DOB	Relationship	Ok to Release Results	Any Comments

Jensen
CENTER for COSMETIC & PLASTIC SURGERY

			☐ Yes ☐ No	
			☐ Yes ☐ No	