Mark Crispin, MD, FACS *5673 Peachtree Dunwoody Rd, Suite 100*
Crispin Plastic Surgery *Atlanta, Georgia 30342*

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Social Security #: _____ Sex: Female Male Marital Status: _____

Address: _____ City/State/Zip Code: _____

Home #:_____ Work #:_____ Cell #:_____

Email Address: _____ Preferred Contact Method: Cell Email Other_____

Please Circle: Employed Retired Student Other Employer: _____

GUARANTOR OR RESPONSIBLE PARTY

- o Same as Patient If not, relationship to patient:_____

Name: _____ Date of Birth:_____

Address: _____ City/State/Zip: _____

Phone #: _____ Social Security #: _____

PRIMARY INSURANCE (*NON COSMETIC CONSULTATIONS ONLY***)**

Company Name: _____ Policy Holder Name:_____

ID/Policy #: _____ Group #: _____

EMERGENCY CONTACT

Name: _____ Phone #: _____

- o Dr. Mark Crispin and/or any staff members may discuss matters related to my condition or care with the above named person.**PLEASE INDICATE YOUR PREFERENCE**: YES NO

Referral

Whom may we thank for your referral? _____

- o I have given my insurance card and driver's license to the front office coordinator to be photo copied.

Patient Signature:_____ Date: _____

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PATIENT MEDICAL HISTORY

Height: _____ Weight: _____

Do you have children? Yes No If yes, how many? _____

Do you drink alcohol? Yes No If yes, amount per week? _____

Do you smoke? Yes No If yes, amount per week? _____ Did you ever smoke? Y N

Do you have a family history of any of the following? *Please Circle if applicable*

Bleeding Disorder Blood Clots Melanoma Breast Cancer Psychiatric Disorder

If you indicated yes to any of the above, please list family member (s):_____

Have you ever tested positive for HIV or Hepatitis? *Please Circle* Yes No *If yes, please specify: _____

Primary Care Physician Name: _____ Phone #:_____

Reason for Consultation today: _____

Medications (Includes Weight Loss Preparations, Blood Thinners, Vitamins, Aspirin, Anti-inflammatories, Etc.)

_____

_____

List any Medication Allergies: _____

_____

List any surgeries you have had:_____

_____

Women Only

Have you had a full term pregnancy? *Please circle:* Yes No

When was your last mammogram?_____ Results? _____

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Have you had or do you have any of the following: *Please check next to applicable condition*

Anemia		Mitral Valve Prolapse	
Aneurysm		Muscular Dystrophy	
Angina or Chest Pains		Myocardial Infarction	
Anxiety Disorder		Nasal Airway Obstruction	
Arrythmia		Peripheral Vascular Disease	
Asthma		Pneumonia	
Bleeding Disorder		Polio	
Blood Transfusion		Polyarteritis Nodosa	
Breast Cancer		Prostate Cancer	
Cancer		Psoriasis	
Cold Sores		Pulmonary Disease	
Congestive Heart Failure		Recent Weight Loss	
COPD		Renal Disease	
Deep Vein Thrombosis		Rheumatic Fever	
Depression		Rheumatoid Arthritis	
Diabetes		Sarcoidosis	
Dry Eye Syndrome		Seizure Disorder	
Epilepsy		Skin Cancer	
GI Problems		Stroke	
Glaucoma		Thromboembolism	
Heart Disease		Thyroid Disease	
Heart Murmur		Transient Ischemic Attacks	
Hepatitis		Tubal Pregnancy	
HIV/AIDS		Tuberculosis	
Hypertension		Urinary Tract Infections	
Liver Disease or Jaundice		Varicose Veins	
Lupus		Visual Problems	

If you have not had any of the above illnesses, please initial here: _____

Are there any other medical illnesses you have had that are not listed above?_____

_____

If your injury is due to an accident, was the accident work related? Yes No

Date of Accident: _____Where did accident occur? _____

How did the accident occur? _____

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Separate Corporate Entities:

I understand Plastic Surgery Centre of Atlanta, PC (David B. Brothers, MD) and Crispin Plastic Surgery (Mark E. Crispin, MD, FACS) are separate Georgia corporations. I understand Chrysalis Skincare is a subsidiary of Plastic Surgery Center of Atlanta, PC.

Signature of Patient or Legal Guardian: _____ Date: _____

Receipt of Notice of Privacy Practices Written Acknowledgement Form:

I have received a copy of the Notice of Privacy Practices.

Signature of Patient or Legal Guardian: _____ Date: _____

Payment Agreement:

I understand there may be a consultation fee or co-payment due at the time service is rendered. I have been informed that Dr. Crispin is out-of-network with specific insurances. I understand Crispin Plastic Surgery will file my claim with my primary insurance company only. I am responsible for any co-payment after my primary insurance has processed my benefits. I also authorize Crispin Plastic Surgery to appeal on my behalf for reimbursement of services rendered.

Signature of Patient or Legal Guardian: _____ Date: _____

Authorization of Release of Information:

I authorize the release of any information, including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health care practitioners. I authorize and request my insurance company to pay DIRECTLY to the doctor or doctor's corporation insurance benefits otherwise payable to me unless I have already paid. I understand my insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all service rendered on my behalf or my dependents.

Signature of Patient or Legal Guardian: _____ Date: _____

Photography Consent:

I hereby authorize Crispin Plastic Surgery to take confidential photographs of myself in whole or in part for ONLY MY MEDICAL RECORDS OR INSURANCE IF REQUESTED. These photographs will remain property of the above named corporation.

Signature of Patient or Legal Guardian: _____ Date: _____

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Cancellation Policy

We understand there are times when you must miss an appointment due to emergencies or obligations for work or family. In order to be respectful of the medical needs of other patients, please be courteous and call Crispin Plastic Surgery promptly if you are unable to come to your scheduled appointment. This will ensure adequate time to reallocate the appointment to another patient.

If it is necessary to cancel your schedule appointment, we require you call at least 24 hours in advance. Appointments are in high demand and your early cancellation will give another patient the possibility to be seen in a timely manner.

If an appointment is not cancelled at least 24 hours in advance,

you will be charged a $75 fee to be paid prior to receiving further services.

Print Name: _____ Date: _____

Signature of Patient or Legal Guardian: _____

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Patient Name:_____ Date: _____

What is the reason for your visit today? _____

Other than services you are here for today, what additional services would you like to learn about?

Please check all that apply

Skin care advice		Smile lines		Neck wrinkles	
Skin care products		Parentheses around mouth		Sun damage	
Injectable treatments		Brown spots/age spots		Facial contouring	
Botox/Juvederm		Drooping brow		Eye lift	
Facial fine lines/wrinkles		Length/Fullness of eyelashes		Facial redness	
Thin lips		Facial fullness		Unwanted hair	
Forehead wrinkles		Mole removal		Dark under eye circles	
Frown lines		Scar revision		Eye puffiness	
Crow's feet		Excessive sweating		Stomach pouch	

- Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		True Age		Older Than
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

Please provide your email address below to receive information about future special and promotions.

Email address: _____

_____ Please initial if you are not interested in any additional services provided at this time.