MELANIE PRINCE, MD
PLASTIC SURGERY

Patient Information

Date_____

Last Name_____ First Name_____ MI_____ Age_____ DOB_____

SS#_____ - _____ - _____ Birth Sex Male □ Female □ Gender Identity_____

If patient is a minor: Parent/Legal Guardian_____ SS#_____ - _____ - _____

Address_____ City_____ State_____ Zip_____

Email Address_____

Home Ph(_____)_____ Cell Ph(_____)_____ Work Ph(_____)_____

Employer_____ Occupation_____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

Emergency Contact_____ Relationship_____ Ph(_____)_____

PCP_____ Address_____ Ph(_____)_____

Pharmacy_____ Address_____ Ph(_____) _____

How did you hear about Melanie Prince, MD?_____

□ Referral_____ □ Friend_____ □ Internet_____ □ Ad_____

Signature

Authorization: I hereby state the above information is true and correct to the best of my knowledge. I authorize Melanie Prince, MD, to release any information acquired in the course of my treatment to my employer, other physicians, and/or institutions, as required for certain claims. I authorize Melanie, Prince, MD, to obtain any information from other physicians or institutions as needed for continuation of care.

Acknowledge of Receipt of Privacy Notice: I hereby acknowledge the receipt of the Notice of Privacy Practices (attached) given to me by Melanie Prince, MD, PA. The notice describes the types of uses and disclosures of my protected health information (PHI) that might occur in my treatment, payment of my bills, or in the performance of health care operations.

You have my permission to discuss my medical care with: _____

Signature: _____ **Printed Name**: _____ **Date**: _____

8201 Cantrell Road, Suite 150 · Little Rock, AR · 72227 · Ph 501.225.3333 · Fax 501.225.3338
www.princeplasticsurgery.com · info@princeplasticsurgery.com

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Medical Questionnaire

Reason for consult_____ Referring MD_____

Height_____ Weight_____ Race_____

Past Medical History: List any medical conditions for which you have been treated

_____

_____

Do you have a history of:

High Blood Pressure		Bleeding Disorders		Diabetes	
Blood Clots / DVT / PE		Cancer: Type_____		HIV / AIDS	
High Cholesterol		Breast Disease		Depression / Anxiety	
Heart Disease		Autoimmune Disease		Kidney Disease	
Heart Attack		Acid Reflux / Ulcers		Stroke	
Asthma		Hepatitis		Seizures	
Thyroid Disease		Sleep Apnea / CPAP		Poor Circulation	

Past Surgical History: List any surgeries you have had

Surgery_____ Year_____ Hospital_____

Surgery_____ Year_____ Hospital_____

Surgery_____ Year_____ Hospital_____

Surgery_____ Year_____ Hospital_____

Surgery_____ Year_____ Hospital_____

Current Medications: Please include name, dose, frequency (Include herbal supplements)

_____

_____

_____

_____

Allergies:

Medication_____ Reaction_____

Medication_____ Reaction_____

Medication_____ Reaction_____

Medication_____ Reaction_____

Anesthesia: Have you or your family ever had difficulty with anesthesia? □ No □ Yes

Please explain_____

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Medical Questionnaire (cont.)

Family History:

	Father	Mother	Children	Siblings	Grandparent	Other
Alive (Y / N)						
Ages						
Health						

Have any of your family ever had blood clots or bleeding? □ No □ Yes

Please explain_____

Social History:

Tobacco use: □ Never □ Previously Quit, Date_____ □ Yes, Type_____ Amount_____

Exposure to Nicotine / Second-Hand Smoke: □ No □ Yes, How Often_____

Alcohol use: □ Never □ Rare □ Occasionally □ Frequently □ Daily, Amount_____

Drug use: □ Never □ Rare □ Occasionally □ Frequently □ Daily, Amount_____

Type of water system in your home: □ Well Water □ City Water

For Women Only:

Bra Size_____ Desired bra size_____ Are you currently breastfeeding □ Yes □ No

Number of pregnancies_____ Number of living children_____ Ages_____

Date of last menstrual period_____ Could you possibly be pregnant □ Yes □ No

Last mammogram_____ Results_____ Facility_____

Last PAP smear_____ Results_____

Review of Systems: Please check the following that currently pertain to you

General	___ Weight changes ___ Fatigue ___ Chills ___ Fevers
Head / Neck	___ Eye pain ___ Excessive tearing ___ Dry eyes ___ Double vision
	___ Difficulty chewing ___ Dentures ___ Hearing loss
Cardiovascular	___ Chest pain ___ Irregular heartbeat ___ Extremity swelling
Pulmonary	___ Shortness of breath ___ Recent cough ___ Congestion
Gastrointestinal	___ Ulcers ___ Heart burn ___ Constipation ___ Diarrhea
Genitourinary	___ Pain with urination ___ Kidney stones
Skin	___ New or changing lesion ___ Previous skin cancer ___ Rash
Hematologic	___ Abnormal bleeding ___ Easy brusing
Neurologic	___ Stroke ___ Seizures ___ Sensory loss
Psychiatric	___ Depression ___ Anxiety ___Alcoholism ___ Drug dependence

If yes to any of the above, please explain:

_____

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Authorization for Use and Release of Medical Photos

Required:

I, _____, agree that Melanie Prince, MD, or designated representative, may take and use preoperative, intraoperative and postoperative photographs of my person for my confidential clinical record. The photographs will remain property of Melanie Prince, MD, PA.

Signature: _____ **Printed Name**: _____ **Date**: _____

Optional:

I grant my permission for the use of photographs, videotapes, or case information for the following additional purposes below. I understand that such consent is strictly on a voluntary basis. While every effort is taken to preserve the confidentiality of my identity, some photographs may make me identifiable to others. I will not be identified by name in any publication. I understand I will not be entitled to monetary payment as a result of use of the images. I consent for my photographs to be used by Melanie Prince, MD, PA, in the following education and scientific settings:

- At Dr. Prince's office to help educate other patients
- On Dr. Prince's website to help educate other patients
- Lectures given by Dr. Prince to the general public for education purposes
- Newspaper and/or magazine articles in which Dr. Prince participates
- On social medical platforms to help educate patients
- Television programs in which Dr. Prince participates.

Signature: _____ **Printed Name**: _____ **Date**: _____

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Financial Policies

Appointment Cancellation Policy: Prince Plastic Surgery is committed to providing each of our patients with exceptional care. When a patient cancels without giving enough advance notice, they prevent another patient from being seen. Please call our office two business days prior to your scheduled appointment to notify us of any changes or cancellations.

> **Consultation Appointments**: If two business days prior notification is not given, the $150 consultation fee will be forfeited. If greater than two business days notification is given, the $150 consultation fee will be converted to an in-office credit that can be used on other products and services.
>
> **Non-Consultation Appointments**: If two business days prior notification is not given, a $75 fee will be charged to the credit card provided at the time of booking.

All payments are expected at the time of service: Payment is required at the time services are rendered unless other arrangements have been made in advance. We accept cash, personal checks (in-state only), credit/debit card, Care Credit, and PatientFi. Refunds needed for credit/debit card purchases will be issued to the card that was used at the time of payment. Care Credit and PatientFi are accepted for cosmetic services only.

Credit Card on File Authorization: For your convenience, our office can keep your credit card information on file for any future charges you may incur. Your card will automatically be charged for each account balance as it occurs. It is your responsibility to notify us of any changes to the credit card information provided. This service is optional and is not required and may be cancelled at any time by submitting a written request. Please initial one of the following:

_____ Please keep my credit card information on file. I authorize Prince Plastic Surgery to charge my card for all future services and fees.

_____ I prefer to receive paper statements for any future services.

Cosmetic: All cosmetic fees must be paid prior to service. To schedule surgery, a deposit of $1,000 is required to reserve operating room time, which will be applied to your balance. The deposit is non-refundable. The deposit must be paid with either cash, check, or credit/debit card. Care Credit and PatientFi will not be accepted for the deposit. The remaining balance must be paid 8 weeks prior to surgery and may be paid by any method you choose. If payment has not been received, surgery may be cancelled, and the deposit will not be returned. If surgery is cancelled with less than a 8 week notice, the entire surgery fee becomes nonrefundable.

Additional Information: Disability forms: There will be a $25.00 service charge for those requiring disability form completion. This will be due prior to the forms being sent. Returned check: There will be a $25.00 service charge on any returned checks.

Signature: _____ Printed Name: _____ Date: _____

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