Plastic Surgery Arts of West Michigan
Ryan E. Dodde, II, MD

3124 N Wellness Dr Ste 10
Holland MI 49424
Office-(616)-738-5870 Fax-(616)738-5872

Patient Information

Today's Date: _____

(Please use black or blue ink.)

Patient's First Name: _____ Middle Initial: _____Last Name: _____
Address: _____ City: _____State_____ Zip _____
Home Phone: _____ Work Number: _____ Cell Number: _____
Alternative Number: _____Date of Birth: _____ Social Security Number: _____
Marital Status: Married _____ Single_____ Widowed_____ Divorced_____
Place of Employment: _____ Phone Number: _____
Emergency Contact Name: _____Phone Number: _____ Relationship _____
May we send you reminder cards? Yes or No May we leave you a message? Yes or No
May we send you emails? Yes or No Email Address _____
Primary Language_____ Race_____ Ethnicity (Hispanic or Latino) _____

~Complete Only for Minor Children receiving treatment~

Parents Name- Father_____ Mother _____
Father's Date of Birth _____ Mother's Date of Birth _____
Father's Social Security Number: _____ Mother's SSN _____
Father's Place of Employment: _____
Mother's Place of Employment: _____

I consent to allow Dr. Ryan Dodde II to treat my minor child
_____ (Parent or Guardian of Patient)

Insurance Information Must be completed:

Health Insurance Company: _____
Contract or Policy No: _____ Group Number: _____
Type of Contract: HMO☐ASO☐ PPO☐ POS☐ Traditional Plan ☐ Unknown☐
Name of Subscriber/Insured *(name of person who has insurance)*:_____ DOB: _____
Insured Employer_____ SSN: _____
Secondary Insurance Company: _____ Policy No: _____Group No.: _____
Name of Subscriber: _____ DOB: _____ SSN: _____
Insured Employer _____
Reason for Visit to our office today:

_____
_____
_____

Have you seen any other Physicians for treatment? Yes or No
If Yes, Physician Name: _____

Primary Care Doctor: _____

Plastic Surgery Arts of West Michigan
History Intake Form

Patient Name: _____

Please answer ALL the questions as accurately as possible. If you do not understand the questions, please ask for assistance.

Social History: Alcohol (type and amount per week) _____

Smoking Status: Yes ____ No ____ (Type and Amount Per Day) _____ Year Started Smoking_____

If former smoker, Date/Year started_____ Date/Year Quit _____ Height _____ Weight _____

List all Allergies and Reaction (see below) Allergic to eggs? Y or N Allergic to influenza immunization? Y or N

_____

_____

Current Medications you take including herbals, vitamins, supplements and/or any over the counter medications:

Name Dosage Reason for medication

_____

_____

_____

_____

_____

_____

_____

_____

Past Anesthesia Problems N☐ Y☐ If yes, please explain_____

Past Surgical Procedures

_____

_____

Have you ever had an influenza immunization? N☐ Y☐ Where did you receive the influenza immunization? _____

Family History: Please circle yes (y) or no (n). Has any blood relative ever had the following?

No relevant Family History ____ Unknown-Adopted ____

Breast Cancer	Y or N	High Blood Pressure	Y or N	Kidney Disease	Y or N	Diabetes	Y or N
Malignant Melanoma	Y or N	Thyroid Disease	Y or N	Depression	Y or N	Glaucoma	Y or N
Stroke	Y or N	Malignant Hyperthermia	Y or N	Blood Clots	Y or N	High Cholesterol	Y or N
Autoimmune Disorder	Y or N	Colon Cancer	Y or N	Liver Disease	Y or N	Lung Disease	Y or N
Obesity	Y or N	Skin Cancer	Y or N	Premature Coronary Heart Disease			Y or N

Past Medical History: Please circle yes or no. Have you ever had any of the following?

Heart Disease	Yes or No	Cancer	Yes or No	Stomach Ulcer	Yes or No
Arthritis	Yes or No	Glaucoma	Yes or No	Kidney Disease	Yes or No
Rheumatic Fever	Yes or No	Asthma	Yes or No	Thyroid Disease	Yes or No
Anemia	Yes or No	AIDS or HIV+	Yes or No	Bleeding Tendency	Yes or No
Diabetes	Yes or No	Stroke	Yes or No	Mitral Valve Prolapse	Yes or No
High Blood Pressure	Yes or No	Malignant Hyperthermia	Yes or No	Deep Vein Thrombosis (DVT)	Y or N
MRSA	Yes or No				

Other_____

Review of Systems: Please circle yes or no. Do you have now or have you had within the past year:

Weight Change	Yes or No	Swollen feet/ankles	Yes or No	Seizures	Yes or No
Dry eyes/Hay fever	Yes or No	Skin Rash	Yes or No	Joint or Muscle pain	Yes or No
Chronic pain	Yes or No	Chronic Diarrhea	Yes or No	Swollen Lymph Nodes	Yes or No
Chest Pain	Yes or No	Jaundice	Yes or No	Easy Bleeding	Yes or No
Rapid Heart Beat	Yes or No	Depression	Yes or No	Easy Bruising	Yes or No

If yes, please explain _____

Women ONLY:

Date of last period _____Number of pregnancies_____ Number of live births_____ Date of last mammogram _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Patient's Signature: _____ Date: _____

Plastic Surgery Arts of West Michigan
3124 North Wellness Drive Suite 10
Holland MI 49424
616-738-5870~616-738-5872 (fax)

Authorization for Disclosure of Medical Information

I authorize you to furnish a copy of my entire medical records and/or medical information to Dr. Ryan E. Dodde II and/or his representative at Plastic Surgery Arts of West Michigan.

I hereby release you from all legal responsibility or liability that may arise from the release of the above described medical records and/or medical information.

I also authorize Dr. Ryan E. Dodde II and/or his representative to take photographs of me for pre-operative and post-operative follow up care, health insurance and educational purposes. I understand that my name will be kept confidential regarding any use of these photographs.

Patient or Legal Guardian's Signature _____ Date _____

Witness signature _____ Date _____

Assignment of Benefits and Signature on File

I hereby authorize my Insurance Company to pay by check made payable and mailed directly to:

Plastic Surgery Arts of West Michigan
3124 N. Wellness Drive Suite 10
Holland MI 49424

For the medical and surgical benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the services rendered. I understand that as a courtesy to me, the Plastic Surgery Arts of West Michigan will file a claim with my insurance company on my behalf.
However, I am financially responsible for and hereby do agree to pay, in a current manner, any and all charges not covered by the insurance payment. If it is necessary to file a formal collection action, I agree to pay all costs, including reasonable attorney's fees incurred by the medical center in the collection of the outstanding fees.

Actual Plan Benefits can not be determined until the claim is received by your insurance company and is based upon their determination of medical necessity. The information received from the above stated is not a guarantee of payment.

Patient or Legal Guardian's Signature _____ Date: _____

Plastic Surgery Arts of West Michigan
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Holland MI 49424

Acknowledgment of Receipt of Privacy Practices

HIPAA Notice of Privacy Practices states that because of new HIPAA regulations, if any family member or friend were to be coming with the patient to the office or calling the office on the phone, the practice would need the patient's permission to be able to speak to that person or for that person to be able to go into the room with the patient. There is a copy of the Notice in our office if the patient would like to read this or would like a copy.

By signing below, I acknowledge that I have received and/or it has been explained to me the Notice of Privacy Practices from Plastic Surgery Arts of West Michigan.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Documentation of Failure to Obtain Signed Acknowledgement

On this date: _____

This practice presented the Acknowledgement of Receipt of Notice of Privacy Practices form to the following Patient:
_____.

The patient refused to provide a signature when requested.

_____
Signature of Office Staff

Patient Authorization for use/disclosure of Health Care Information

Patient Name: _____ Date of Birth _____

I request and authorize the above named Practice to release my personal health care information to the persons listed below:

Names of Family or Friends Authorized — Relationship to Patient

_____
_____
_____
_____

This Request and Authorization applies to:

☐ Today's Visit ONLY

☐ All Health Care Information until authorization is terminated in writing by me.

___ Other: _____

Patient Signature _____ Date _____
Relationship (parent, legal guardian, personal representative, etc.)

Authorization for Disclosure of Photographs

I, the undersigned, authorize Dr. Ryan E. Dodde II and/or his representative to utilize photographs of myself for pre-operative, post-operative, and follow up care at Plastic Surgery Arts of West Michigan. I understand there is a possibility that I may be identifiable in these photographs. I understand my name and all personal health information regarding use of these photographs will be kept confidential.

I hereby release you from any and all legal responsibility or liability that may arise from the viewing of the above described photographs.

Patient or Legal Guardian's Signature	*Date*
Print Name	*Date of Birth*
Witness Signature	*Date*

Patient Initials

Optional ***By initialing, I give permission for use of pictures described above for educational purposes to other potential patients inquiring about plastic surgery in the office and/or use on website for education and procedure inquiry. I understand my name and all personal health information regarding use of these photographs will be kept confidential.***

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