DALLAS RHINOPLASTY CENTER, P.A.

C. SPENCER COCHRAN, M.D. | AESTHETIC & RECONSTRUCTIVE NASAL SURGERY

NEW PATIENT INFORMATION

Name _____ How should we address you? _____

Age _____ Sex _____ DOB _____ SS# _____

Address _____

City _____ State _____ Zip _____

Home # _____ Wk# _____ Cell # _____

Email Address _____

Occupation _____ Employer _____

Marital status: ❑ married ❑ single ❑ divorced Spouse's name _____

Reason for consultation/areas of concern:

How did you hear about us? ❑ Friend ❑ Doctor ❑ Former Patient ❑ Internet: _____

Whom may we thank for this referral?

Name _____

Address _____

Parent/Spouse/Guardian

Name _____

Address _____

City _____ ST ____ Zip _____

HM ( ) _____ Wk ( ) _____

Emergency Contact

Name _____

Relationship _____

Phone ( ) _____

Guarantor

Name _____

Relationship _____

Address _____

City _____ ST ____ Zip _____

HM ( ) _____ Wk ( ) _____

DOB _____ Sex _____

Employer _____

Phone ( ) _____

Financial responsibility

❑ I will be responsible for all financial charges

❑ The guarantor will be responsible for all financial charges

I certify the above information is correct to the best of my knowledge. I understand that I am financially responsible for all charges whether or not covered by insurance. I also have received the Notice of Financial Policies on the date(s) signed.

Signature _____ Date _____

8144 WALNUT HILL LANE, SUITE 170 DALLAS, TEXAS 75231

(TEL) 214.369.8123 (FAX) 214.369.2984

WWW.RHINOPLASTY-USA.COM WWW.GUNTER-CENTER.COM

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MEDICAL HISTORY

Name _____ DOB ____/____/____ Age _____

Ht _____ Wt _____ Last physical exam?_____ Lab Work _____ EKG _____ Chest Xray _____

Do you have any known allergies to medications? ❑ No ❑ Yes, _____

Do you smoke? ❑ No ❑ Yes If yes, how many packs/day? _____ How Long?_____

Do you drink alcohol? ❑ No ❑ Yes If yes, how many drinks/week? _____

Have you ever had any previous surgeries? If yes, please describe

YEAR	PROCEDURE	PHYSICIAN	WERE YOU SATISFIED?

MEDICATIONS

Are you taking prescriptions for the listed conditions?

	No	Yes	Medications
Anemia	❑	❑	_____
Asthma	❑	❑	_____
Diabetes	❑	❑	_____
Heart Disease	❑	❑	_____
High Blood Pressure	❑	❑	_____
Blood Thinners	❑	❑	_____
Sleep	❑	❑	_____
Thyroid	❑	❑	_____
Fever Blister	❑	❑	_____

Are you taking any of the following medications:

	No	Yes	Amount/Frequency
Aspirin	❑	❑	_____
Motrin(Ibuprofen)	❑	❑	_____
Aleve (Naproxen)	❑	❑	_____
Birth Control	❑	❑	_____
Hormone	❑	❑	_____
Chronic Steroids	❑	❑	_____
Pain Pills	❑	❑	_____
Vitamins	❑	❑	_____
Herbal Supplements	❑	❑	_____

Please list any additional medications you are taking:

_____

_____

MEDICAL CONDITIONS

Please list any medical condition that you currently suffer from, or have experienced in the past:

	No	Yes	Please Describe
Angina/Chest Pain	❑	❑	_____
Anemia	❑	❑	_____
Arthritis	❑	❑	_____
Asthma	❑	❑	_____
Cancer	❑	❑	_____
Colitis/IBD	❑	❑	_____
Diabetes	❑	❑	_____
Heart Disease	❑	❑	_____
High Blood Pressure	❑	❑	_____
Hepatitis A/B/C	❑	❑	_____
HIV/AIDS	❑	❑	_____
Kidney Disease	❑	❑	_____
Psychiatric Disorder	❑	❑	_____
Depression	❑	❑	_____
Anxiety	❑	❑	_____
Seizures	❑	❑	_____
Thyroid Disease	❑	❑	_____
Lung Disease	❑	❑	_____
Shortness of Breath	❑	❑	_____
Ankle Swelling	❑	❑	_____
Bleeding Disorder	❑	❑	_____
Blood Clots	❑	❑	_____
Anesthesia Problems	❑	❑	_____

Have you ever had a Staph/MRSA infection in the past? ❑ No ❑ Yes If yes, please indicate where on your body the infection was located and how/when it was treated _____

Please include any additional information that we should know to better care for you:

_____

I confirm that the above is true and accurate to the best of my knowledge.

Signature_____ Date _____

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REASON FOR CONSULTATION

Please check one or more of the area that most concern you:

Face	Skin
☐ Nose (appearance)	☐ Botox
☐ Nose (breathing difficulties)	☐ Fillers
☐ Nose (appearance & breathing)	☐ Facial Peels
☐ Chin	☐ Photofacial
☐ Ears	☐ Permanent Makeup

Are you expecting insurance to pay for a portion of the procedure?

How long has this been a concern?

What have you done to address this concern in the past?

Describe the treatments (including dates for surgeries):

Are there any other areas of concern that you would like to discuss?

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PATIENT MEDICAL INSURANCE INFORMATION

It is not necessary to fill out this form if the surgery you are discussing is strictly cosmetic. If insurance will apply to the surgery, please complete the following information and have the receptionist photocopy your insurance card.

ALL INSURANCE PATIENTS SHOULD SIGN BOTH PLACES
DESIGNATED AT THE BOTTOM OF THE PAGE

PRIMARY INSURANCE

Primary Insurance:_____

Address & Phone # of Ins. Co: _____

Name of Insured:_____

Address (if different from patient): _____

Insured's Employer: _____

Insured's ID or SS#:_____ Group/Policy#:_____

SECONDARY INSURANCE

Does The Patient Have Additional Insurance Coverage? _____

If yes, name of Insurance Co:_____

Address & Phone # of Ins. Co:_____

Name of Insured:_____

Address (if different from patient):_____

Insured's Employer:_____

Insured's ID or SS#:_____ Group/Policy#:_____

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the undersigned physician for services described.

Signature: _____ Date: _____
(Insured/Authorized Person)

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process claims and/or predetermination letters. This authorization will apply for 2 years from the date listed below.

Patient's signature: _____ Date: _____
(or guardian, if a minor)

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ____ **Patient ID #:** ______________________

I hereby acknowledge that I have received a copy of DALLAS RHINOPLASTY CENTER's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

I AUTHORIZE THAT MESSAGES FOR PATIENT PERTAINING TO APPOINTMENTS AND INSTRUCTIONS REGARDING PATIENT CARE MAY BE LEFT

- ❑ at work
- ❑ cell phone
- ❑ with spouse
- ❑ at home/voicemail
- ❑ via email
- ❑ other relative

____

Signature of Patient or Legal Representative

____

Date

____

Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

- -

(FOR OFFICE USE ONLY)

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

______________________________ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

____

____

____

____

____

- ☐ Other (Specify)

____

____

____

____

WILL INSURANCE HELP PAY FOR MY SURGERY?

If insurance does cover any functional procedures, we will have to call your insurance company, get your benefits, send them to the surgery center for an estimate of what you will owe them the day of surgery, write a letter to your insurance company to see if they will approve the functional portion, etc. All insurance carriers vary, but it could take anywhere from 2-5 weeks to hear back from your insurance company!

By calling your insurance company prior to your visit to obtain your benefits, I can better give you an idea of what your out of pocket expense might be while we go over fees after you have seen the doctor. Otherwise, you leave here only knowing the doctor's surgical fee and not what you will need to pay him before surgery nor will you have any idea what you might be paying the surgery center!

If you are in no hurry to have surgery and don't mind waiting perhaps a month or so to know what you're out of pocket expenses might be, then there is no need to contact your insurance company prior to seeing the doctor. But if you want surgery sooner rather than later and want to know if it would be worth finding out if your insurance will cover the functional portion of your surgery, please call your insurance carrier and ask your insurance the following:

In-Network - Deductible $ _____
How much has been met? _____
In-Network Co-Insurance $ _____
Out of pocket $ (this is the surgical facility)_____

Out-of-Network - Deductible $ _____
How much has been met? $_____
In-Network Co-Insurance $ _____
(Dr. Cochran's fee) Out of pocket $ _____

It's a little confusing, but if you can bring this information with you I think it might be beneficial to you!

Jan

Jan Phillips
8144 Walnut Hill Lane, Suite 170
Dallas, Texas 75231
tel 214.369.8123 fax 214.369.2984
jan@gunter-center.com

DALLAS RHINOPLASTY CENTER, P.A.

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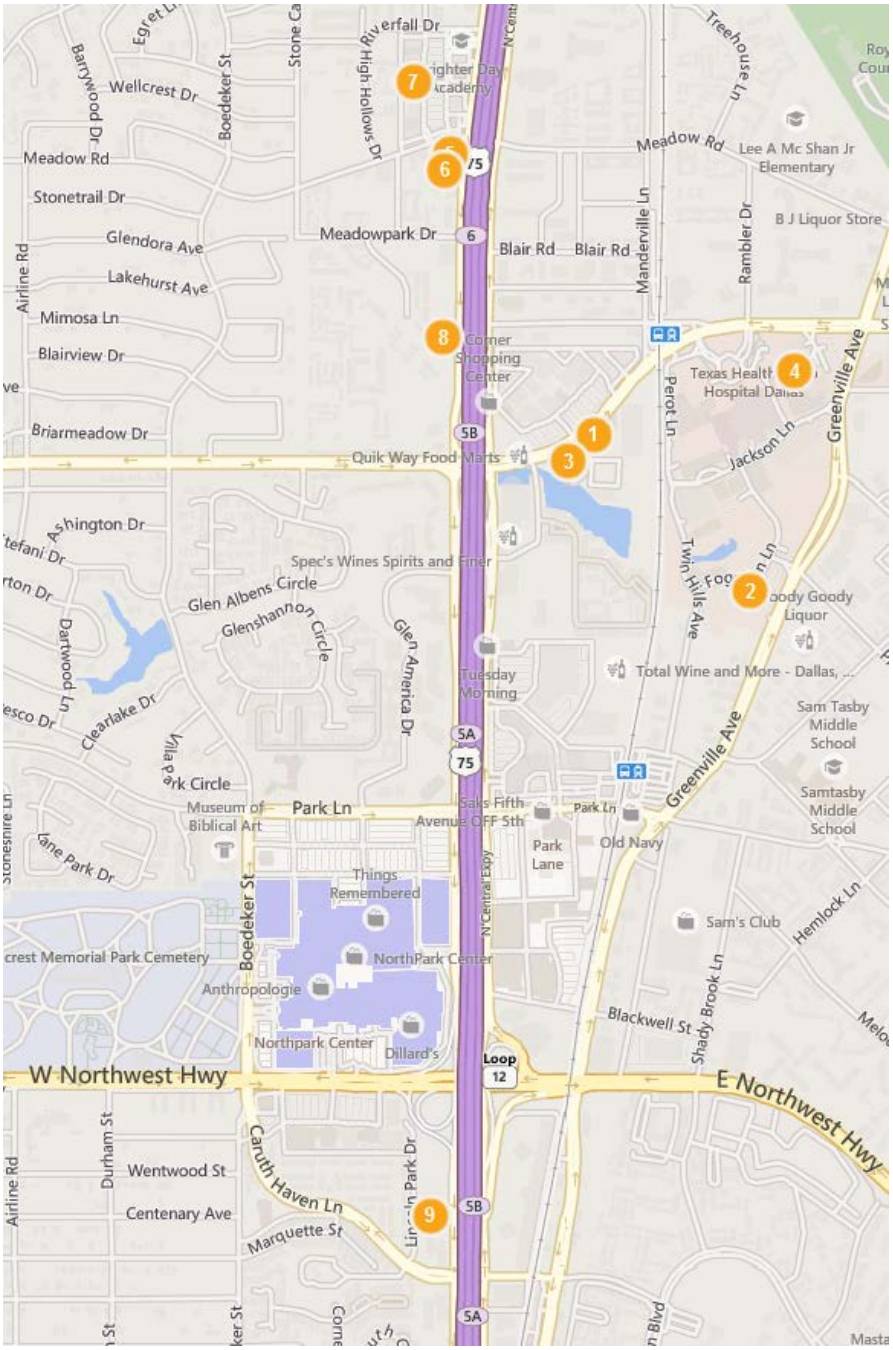
We are conveniently located in North Dallas near North Central Expressway (Hwy 75) and Walnut Hill Lane on the 1st Floor (Suite 170) of the MHBT Building.



1. **Dallas Rhinoplasty Center**
   8144 Walnut Hill Lane, Suite 170
   Dallas, Texas 75231
   (214) 369-8123

2. **Texas Institute for Surgery**
   7115 Greenville Ave
   Dallas, TX 75231
   (214) 647-5300

3. **CVS Pharmacy**
   8024 Walnut Hill Ln
   Dallas, TX 75231
   (214) 368-3050

4. **Southwest Diagnostic Imaging**
   8230 Walnut Hill Ln
   Dallas, TX 75231

5. **Residence Inn**
   10333 N Central Expy
   Dallas, TX 75231
   (214) 750-8220

6. **Marriot Courtyard**
   10325 N Central Expy
   Dallas, TX 75231
   (214) 739-2500

7. **Tom Thumb Pharmacy**
   10455 N Central Expy
   Dallas, TX 75231
   (214) 369-7328

8. **La Quinta Inn**
   10001 N Central Expy
   Dallas, TX 75231
   (214) 361-8200

9. **Hyatt House Dallas/Lincoln Park**
   8221 N Central Expy
   Dallas, TX 75225
   (214) 696-1555

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