COSMETIC PLASTIC SURGERY OF ILLINOIS
5401 N. Knoxville #416 Peoria, IL 61614
309.495.0077 OR 309.495.0038
Eric T. Elwood, MD FACS Glyn E. Jones, MD FACS
https://cosmeticplasticsurgeryofillinois.com/

PATIENT INFORMATION (Please Print)

If you do not understand any question, please ask for assistance.

Last Name: _____ First Name: _____ MI: ___ Nickname: _____ Date: _____

Street Address: _____ Apt: _____ City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____ Social Security #: _____ Date of Birth: _____ Age: _____

Marital Status (circle): __Single __Married __Widow __Divorced __Domestic Partner Cell Phone #: _____

Email: _____ Best phone # and time to be contacted:
_____

Employer's Name: _____ Occupation: _____ Work Phone: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

School Name: _____ School Address: _____ City: _____ State: _____ Zip: _____

Spouse/Parent's Name: _____ Phone #: _____

Emergency Contact Name &: _____ Phone #: _____

Relationship: _____

PRIMARY INSURANCE

Policyholder's Last Name: _____ First Name: _____ MI: _____

Relationship to Patient: _____ Date of Birth: _____

Insurance Company Name: _____

Policy #: _____ Group #: _____

SECONDARY INSURANCE

Policyholder's Last Name: _____ First Name: _____ MI: _____

Relationship to Patient: _____ Date of Birth: _____

Insurance Company Name: _____

Policy #: _____ Group #: _____

How did you hear about Cosmetic Plastic Surgery of Illinois? _____

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Insurance Authorization and Assignment of Benefits

I hearby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, Medicaid, private insurance and other health plans to Illinois Cosmetic and Plastic Surgery, a division of Peroria Surgical Group, Ltd. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as a valid original. I understand that my insurance company may not cover the procedure and/or services that I am receiving because it's considered a non-covered service. The insurance companies for reasons such as pre-exsisting condition, cosmetic procedure diagnoses and other reasons that they regulate, determine non-covered services. I agree to pay all fees for any diagnosis or procedure deemed non-covered as an out-of-pocket expense. I hereby authorize said assignee to release all information needed to secure payment. I understand that all pathology studies and cultures sent out will be billed by the specified laboratories and/or my insurance. I understand that I am responsible for all deductible and co-payment amounts at the time of each visit in accordance to the guidelines and terms of my insurance policy. Further, I understand that any verification of provider or eligibility status with a health plan and any description of benefits is not a guarantee of payment. All charges are paid based on benefits and eligibility status at the time that claims are received.

Signature: _____ Date: _____

Release of Medical Information

I authorize the release of any medical or other information necessary to process claims pertaining to my medical or surgical treatment.

Signature: _____ Date: _____

If Above Patient is a Minor

I authorize the staff to perform the necessary medical services my child may need.

Signature: _____ Date: _____

WORKER'S COMPENSATION

Were you hurt on the job? ___**YES OR** ___ **NO** Date of Injury:_____

Name of Employer/Company Where You Were Hurt: _____

Manager Name: _____ Phone #: _____

Name of Worker's Comp Insurance Company: _____ Address: _____

City: _____ State: _____ Zip: _____ Claim #: _____

Claim adjuster: _____ Phone #: _____

Last day worked: _____ Date returned to work: _____

Referring Physician: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary care physician: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

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Name: _____ DOB: _____

Primary Care Doctor: _____ Phone: _____

1. Please list all doctors that you currently see:

_____

2. Please list medications, vitamins and supplements: _____

_____

3. Please list all allergies and type of reaction: _____

_____

4.What is your reason for seeing the provider today?

_____

5. Past Medical History (mark all that apply)

- ☐ No medical history
- ☐ Currently taking blood thinners
- ☐ Coronary artery disease
- ☐ Prior heart attack
- ☐ High blood pressure
- ☐ Atrial fibrillation
- ☐ High cholesterol
- ☐ Stroke
- ☐ Congestive heart failure
- ☐ COPD/emphysema
- ☐ Asthma
- ☐ GERD (esophageal reflux)
- ☐ Sleep apnea
- ☐ Diabetes
- ☐ Hypothyroidism/hyperthyroidism
- ☐ Seizure disorder
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Kidney disease
- ☐ Anxiety
- ☐ Depression
- ☐ Cancer
- ☐ Anemia
- ☐ Other: _____

6. Past Surgical History (mark all that apply)

- ☐ No surgical history
- ☐ Tonsillectomy
- ☐ Appendix
- ☐ Gallbladder
- ☐ Hernia repair
- ☐ Gastrointestinal surgery
- ☐ Hemorrhoidectomy
- ☐ Back surgery
- ☐ Heart surgery
- ☐ Carotid artery surgery
- ☐ Pacemaker/defibrillator
- ☐ Heart valve replacement
- ☐ Breast surgery
- ☐ Cesarean section
- ☐ Tubal ligation
- ☐ Hysterectomy
- ☐ Dilation and curettage
- ☐ Prostate surgery
- ☐ Adverse reaction to anesthesia
- ☐ Blood transfusion
- ☐ Reaction to blood transfusion
- ☐ Other: _____

7. Family History (mark all that apply)

- ☐ Heart disease
- ☐ Heart attack
- ☐ Stroke
- ☐ High blood pressure
- ☐ Bleeding disorders
- ☐ Diabetes
- ☐ Pancreatic cancer
- ☐ Colon cancer
- ☐ Breast cancer
- ☐ Ovarian cancer
- ☐ Uterine cancer
- ☐ Prostate cancer
- ☐ Other form of cancer

Mother: living or deceased (circle one)
Age/Cause_____
Father: living or deceased (circle one)
Age/Cause_____

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Name: _____ DOB: _____

Primary Care Doctor: _____ Phone: _____

8. Social History

Marital Status:
☐ Single
☐ Married
☐ Widow
☐ Separated
☐ Divorced
☐ Significant other

Living Situation:
☐ Alone
☐ With spouse
☐ With family
☐ Assisted living/nursing home
☐ Significant other
☐ Foster care

Religious Affiliation: _____
History of drug use: ☐ yes ☐ no
Alcohol use: ☐ yes ☐ no
Tobacco use: ☐ yes ☐ no

9. Females Only

Age at first period: _____
Were they abnormal? ☐ yes ☐ no
Date of last period: _____
Current bra size: _____
Are you currently pregnant?
_____

Have you ever been pregnant?
_____
Age at first pregnancy _____
How many pregnancies? _____
How many live births? _____
Any stillbirths: _____
Miscarriages: _____

Abortions: _____
Ectopic (tubal) pregnancy: _____
Pregnancy complications: _____
_____
Did you breastfeed? _____
Ever take birth control pills? _____

10. Testing History

Last screening mammogram date: _____
Diagnostic mammogram date: _____
(please indicate: both, right or left)

Location(s) of mammograms
_____
_____
Colonoscopy date: _____
Results: _____

11. Review of Systems (mark all that apply)

☐ Recent change in weight
☐ Fever
☐ Chills
☐ Fatigue
☐ Night sweats
☐ Wear glasses/contacts
☐ Seeing double
☐ Blurry vision
☐ Nosebleeds
☐ Sore throat
☐ Sinus pain

☐ Chest pain
☐ Palpitations
☐ Use extra pillow at night
☐ Cough
☐ Shortness of breath
☐ Coughing up blood
☐ Diarrhea
☐ Blood in stool
☐ Abdominal pain
☐ Vomiting
☐ Burning with urination

☐ Blood in urine
☐ Loss of bladder control
☐ Male: testicular pain
☐ Breast pain
☐ Breast lump
☐ Joint pain
☐ Back pain
☐ Arthritis
☐ Muscle weakness
☐ Depression
☐ Anxiety

☐ Headaches
☐ Seizures
☐ Dizziness
☐ Numbness/tingling
☐ Intolerance to heat/cold
☐ Easy bleeding
☐ Spontaneous bruising
☐ Blood clots in legs
☐ Recurrent infections

I verify that the above information is true and accurate to the best of my knowledge:

Patient Signature (parent if minor): _____ Date: _____

Patient Printed Name: _____ DOB: _____

Illinois Surgical Specialists, LTD.
Cosmetic Plastic Surgery of Illinois
5401 N. Knoxville Ave. #416 Peoria, IL 61614 Tel: 309.495.0007 Fax: 309.495.0009
Website: https://cosmeticplasticsurgeryofillinois.com/

PRIVACY STATEMENT

I acknowledge there was the opportunity to review a copy of the Illinois Surgical Specialists privacy statement. I understand that I have the following rights regarding my personal health information:

1) The right to be notified in the event of a breach of my personal health information.
2) The right to request that my health plan not be informed of treatment that was paid for in full by me.
3) My consent is required prior to use or disclosure of my psychotherapy notes or the use of my personal health information for marketing purposes.
4) The right to opt out of communications for fundraising purposes.

I wish my private health information to be handled in the following manner:
Illinois Surgical Specialists may contact me or leave me a message for appointments, normal test results and all other correspondence at the following phone number(s) and/or email address:
Home: _____ Work: _____ Cell phone: _____ Email: _____

Please provide a list of the people that we may provide and/or share your medical information with (you may use the back side of this paper for more names if you need more space).
Name of Family Member/POA Relationship Phone #

_____
_____
_____
_____

I agree and understand the above.

Patient Signature: _____ Date: _____

List relationship if signature is other than the patient: _____

REFERRAL RESPONSIBILITY

IF YOUR INSURANCE REQUIRES A REFERRAL FOR YOU TO SEE A PHYSICIAN AT ILLINOIS SURGICAL SPECIALISTS, IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH THE REFERRAL. IF YOUR INSURANCE COMPANY DENIES PAYMENT – DUE TO NO REFERRAL – YOU THE PATIENT AGREE TO PAY ILLINOIS SURGICAL SPECIALISTS IN FULL FOR ANY CHARGES INCURRED DURING YOUR VISIT.

FINANCIAL RESPONSIBILITY & INSURANCE RELEASE INFORMATION

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED INCLUDING MEDICARE, MEDICAID AND OTHER HEALTH PLANS TO THE ILLINOIS SURGIAL SPECIALISTS, LTD. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES EVEN IF THEY ARE NOT PAID BY AN INSURANCE OR HEALTH PLAN. IN THE EVENT ILLINOIS SURGICAL SPECIALISTS SENDS MY ACCOUNT TO A COLLECTION AGENCY DUE TO MY FAILURE TO PAY, I AGREE TO PAY UP TO 40% FOR ALL COLLECTION COSTS PLUS ANY COURT FEES ON THE UNPAID BALANCE. A PHOTOCOPY OR SCAN OF THIS FORM IS TO BE CONSIDERED AS VALID AS THE ORIGINAL. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT. I GIVE PERMISSION FOR ILLINOIS SURGICAL SPECIALISTS TO APPEAL ANY DENIALS FROM MY INSURANCE ON MY BEHALF.

I agree and understand the above.
Patient Signature: _____ Date: _____

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PATIENT PHOTOGRAPH CONSENT AND RELEASE FORM

PATIENT: _____ **DATE OF BIRTH:** _____

Instructions

This is a consent document that has been prepared to help inform you concerning permission to take photographs and to use these images for a purpose as defined within this consent document. It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

Consent for Photography / Authorization for Publication

I hereby acknowledge that I have been advised that photographs and videos will be taken of me or parts of my body before, during and after my surgical procedure(s) and/or treatment. These photographs will be taken by one of the members of _____ medical staff.

I hereby authorize _____ and/or their associates to take photographs and/or video before, during and after surgical procedure(s) or treatment. I hereby give my consent for _____ to use the photographs under the following circumstances:

I agree that the images may be (please check YES or NO to show type of consent):

	YES	NO
1. USED BY HEALTH PROFESSIONALS FOR EDUCATION AND TRAINING *(for professional medical purposes deemed appropriate including but not limited to showing these images for medical education, patient education, lay publication or during lectures to medical or lay groups)*	___	___
2. USED IN PAPER OR ELECTRONIC HEALTH PUBLICATIONS *(including but not limited to publication in scholarly journals and textbooks; educational seminars, conferences and scientific exhibits/illustration, etc.)*	___	___
3. USED IN MARKETING/ADVERTISING MATERIALS *(including but not limited to publications and websites, printed materials, commercials, television or film, social media websites, etc.)*	___	___

By signing this form, I acknowledge my consent as indicated above, and I further recognize that this consent form will supersede any other photo consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

DATE: _____

Patient Name (or guardian) (PRINT): _____

Patient (or guardian) Signature: _____

Witness Name (PRINT): _____

Witness Signature: _____

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Patient Name: _____ DOB: _____

Surgeon's Name: _____ Date: _____