

C. Brett Carlin, M.D.
Cosmetic & Reconstructive Surgery
Board Certified
American Board of Surgery and Plastic Surgery

Welcome to our office. We strive to ensure that you are seen at your appointment time, however due to the specialty of our practice, unforeseen circumstances may arise and may cause an unexpected delay. We appreciate your patience and understanding.

** We ask that you allow us 24 hours notice prior to canceling or rescheduling your appointment. **

Patient's Name: _____
Last First Middle Initial

Parent's / Legal Guardian's name (If minor): _____

Address: _____
Street City State Zip

Home Phone #: (____) _____ Work #: (____) _____ Cell #: (____) _____

DOB: _____ Age: _____ Gender: ____Female ____Male

SSN: _____ Marital Status: S M D W Sep.

(REQUIRED. Will be kept confidential)

Please tell us who referred you: _____

*Insurance information is not needed for cosmetic services. For medical services, please complete **all** insurance information. If any spaces are left blank, we will not be able to file your insurance. Please allow us to copy your insurance card(s) as well as your **Driver's License** or **State I.D.***

Primary Insurance: _____ Is this a Cobra Policy? Y / N

Name of Policy holder: _____ Employer: _____

Their DOB (required) _____ If not policy holder, are you: Spouse / Child / Guardian

Secondary Insurance: _____ is this a Cobra Policy? Y / N

Name of Policy holder: _____ Employer: _____

Their DOB (required) _____ If not policy holder, are you: Spouse / Child / Guardian

It is the patient's responsibility to obtain any pre-authorizations from the referring physician, as necessary per your insurance plan. Rescheduling your appointment(s) may be required if not obtained in advance.

1) I authorize payment for medical benefits to C. Brett Carlin, MD for any services furnished to me. I agree that I will be financially responsible for any amount not covered by my insurance or otherwise. I also authorize you to release any of my healthcare information to my Insurance Company as needed. I understand that any insurance denials will be my sole responsibility to investigate and appeal. I permit a copy of this authorization to be used in place of the original.

2) It is the policy of C. Brett Carlin, MD that charges for all services rendered be paid at the time of service unless PRIOR arrangements have been made with the office. I understand that services involving an attorney, worker's compensation or any other 3rd party does not excuse me from my financial obligation to Dr. C. Brett Carlin and will be paid, in full, as requested.

3) All surgeries cancelled within 2 weeks of the scheduled date will incur a \$250 ~non-refundable~ cancellation fee.

4) I authorize Dr. Carlin and his designees to provide me with the appropriate medical care by today's health standards.

Signature: _____ Date: _____

I hereby give consent to C. Brett Carlin, MD to take clinical photographs relevant to my care. I understand that these may include Pre-op, Intra-op and Post-op images. I understand that if my photos are selected for educational purposes, scientific publications or medical education lectures, etc., I will be asked for my written consent prior to use. I also understand that my photos will be submitted to my Insurance company, as required, in an effort to obtain pre-authorization for services.

Signature: _____ Date: _____

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**AUTHORIZATION TO RELEASE MEDICAL INFORMATION
TO INDIVIDUALS / FAMILY MEMBERS**

In accordance with Federal government privacy rules implemented through the Health Insurance Portability & Accountability Act of 1996 (HIPPA), C. Brett Carlin, M.D. or his staff may not discuss your condition with others, including family members, unless we obtain your written consent to do so. The law stipulates that in the event of a critical emergency and you are unable to give your authorization, these rules may be waived.

____ **I do NOT** authorize C. Brett Carlin, M.D. or his staff to release any or all information concerning my medical care to any individual except in the event of a critical emergency.

____ **I authorize** C. Brett Carlin, M.D. and his staff to discuss / release any and all information concerning my medical care to the following individuals:

Name Relationship to patient

Name Relationship to patient

Patient signature *Date*

C. Brett Carlin and staff
Witness *Date*

Medical Questionnaire

Please tell us why you are here (circle all that apply):

- | | | | | | |
|---------------------|------------------|----------------|-----------------------|-------------------------------|-------------|
| Breast Augmentation | Breast Reduction | Breast Lift | Breast Reconstruction | | |
| Liposuction | Tummy Tuck | Panniculectomy | Protruding Ears | Cleft ear (torn earring hole) | |
| Face Lift | Neck Lift | Brow Lift | Eyelid Lift | Scar Revision | Lacerations |
| Burn Injury | Chemical Peel | Botox | Restylane | Juvaderm | |

Other: _____

Please be specific about what and why you have concerns about the above: _____

Have you consulted any other Physicians about this? If so, who and when: _____

Please list all previous operations (including cosmetic procedures)? _____

Were there any complications? _____

Please list any current medical conditions: _____

Please list current medications, including vitamins and over the counter medications: _____

Please list any allergies to medications: _____

Have you ever received an injection of local anesthesia (Novocain, Lidocaine, etc.)? _____

Did you experience any type of reaction? _____

Do you smoke or use any tobacco products? _____ How many per day? _____

Do you bruise easily or bleed abnormally? _____ Family members? _____

Signature: _____ **Date:** _____