M'LISS HOGAN, M.D.

PLASTIC & RECONSTRUCTIVE SURGERY

215 E. Gibson Street · Covington, LA 70433
(985) 898.1106 · fax (985) 773.1998 · A LIMITED LIABILITY COMPANY

Patient Demographic Information

Last Name	First Name	Middle	Today's Date

Sex	Date of Birth	Social Security #	Driver's License #
☐ Male ☐ Female			

Mailing Address:	May we send information to this address? ☐ Yes ☐ No		
Street			
City	State	Zip	

Home:		May we leave a message at this number? ☐ Yes ☐ No
Cell:		May we leave a message at this number? ☐ Yes ☐ No
Email:		May we email you at this address? ☐ Yes ☐ No
What is your preferred method of contact? (check all that all that apply)		☐ Email ☐ Home ☐ Cell ☐ Text

Primary Insurance (for non-cosmetic procedures)		Secondary Insurance (for non-cosmetic procedures)	
Subscriber's Name		Subscriber's Name	
Relationship to Patient		Relationship to Patient	
Date of Birth (Subscriber's)		Date of Birth (Subscriber's)	
Social Security #		Social Security #	
Insurance Company		Insurance Company	
ID #		ID #	
Group #		Group #	

		How did you hear about us?
Occupation		☐ Friend/Family:
Employer		☐ Physician:
Employer Phone		☐ Internet
Emergency Contact Person (relative, or other who we may contact regarding your health information)		☐ Reputation / Word of mouth
Name		☐ Magazine
Relationship		☐ Other:
Phone		

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Patient Medical Information

Last Name	First Name	Middle	Today's Date

Height:	Current Weight:	Lifetime Highest Weight:

Reason for visit (please check all that apply):

Face	Breast	Body	Non-Surgical & Reconstructive
☐ Face / Neck Lift	☐ Breast Augmentation	☐ Liposuction	☐ Mole Removal
☐ Brow / Forehead Lift	☐ Breast Lift	☐ Tummy Tuck	☐ Scar Revision
☐ Eyelid Enhancement	☐ Breast Reduction	☐ Thigh Lift	☐ BOTOX
☐ Ear Pinning	☐ Breast Reconstruction	☐ Arm Lift	☐ Skin Care
	☐ Male Breast Surgery	☐ Buttock/Brazilian Lift	☐ Wrinkles
		☐ Labiaplasty	☐ Skin / Tissue Fillers
		☐ Body Contouring after Weight Loss	☐ Lip Enhancement
☐ Other:	☐ Other:	☐ Other:	☐ Other:

Please check any medical problems:

☐ Hypertension	☐ High Cholesterol	☐ Heart Attack	☐ Stroke	☐ Bleeding Disorder	☐ COPD	☐ Other:
☐ Diabetes	☐ Heart Failure	☐ Anemia	☐ Obesity	☐ Cancer	☐ DVT/PE	

Please list any previous surgeries:

☐ Gallbladder	☐ Appendectomy	☐ C- Section	☐ Hysterectomy	☐ Breast Biopsy	☐ Breast Reduction
☐ Other:					

Please list any medications with dosage & frequency:

Please list any allergies to mediations and the reaction you had:

Do you smoke: ☐ Yes ☐ No If so, how may packs per day: ________ How many years: ________

Do you drink alcohol: ☐ Yes ☐ No If so, how many drinks per day / week: ________________

Do you use any of the following:
- Marijuana ☐ Yes ☐ No If so, how often: ____________
- Cocaine ☐ Yes ☐ No If so, how often: ____________
- Other: ________________ If so, how often: ____________

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HAVE YOU EVER HAD:			DO YOU TAKE:		
Uncontrolled bleeding	☐ Yes	☐ No	Birth control pills	☐ Yes	☐ No
Blood clotting issues	☐ Yes	☐ No	Hormone replacement pills	☐ Yes	☐ No
Problems with anesthesia	☐ Yes	☐ No	Fish Oil	☐ Yes	☐ No
Family with anesthesia problems	☐ Yes	☐ No	Aspirin	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No	Ibuprofen (Advil, Motrin)	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Vitamin E	☒ Yes	☐ No
Breast Cancer	☐ Yes	☐ No	Aleve, Naprosyn	☐ Yes	☐ No

Have you ever been pregnant? ☐ Yes ☐ No	Number of pregnancies: ______	Number of deliveries: ______

Do you now or have you in the past any problems related to the following. PLEASE CHECK ALL THAT APPLY.

Allergic/Immunologic	Constitutional Symptoms	Ears / Nose / Throat	Endocrine
☐ Hay Fever ☐ Lupus ☐ Scleroderma	☐ Chills ☐ Fever ☐ Weight Loss - unintended	☐ Frequent Ear Infections ☐ Frequent Nosebleeds ☐ Sinus problems	☐ Diabetes ☐ Excessive Thirst ☐ Thyroid problems ☐ Too hot / cold
Genitourinary	**Integument**	**Psychological**	**Respiratory**
☐ Kidney Stones ☐ Painful Urination ☐ Urinary Frequency ☐ Urinary Retention	☐ Boils ☐ Keloids / Thick Scars ☐ Skin Rash ☐ Skin Cancer	☐ Anxiety ☐ Bipolar Disorder ☐ Depression ☐ Schizophrenia	☐ COPD ☐ Chronic Coughing ☐ Pulmonary Embolism ☐ Shortness of Breath
Musculoskeletal	**Neurological**	**Cardiovascular**	**Hematologic / Oncologic**
☐ Arthritis ☐ Back Pain ☐ Gout ☐ Neck Pain ☐ Osteoporosis	☐ Alzheimer's ☐ Multiple Sclerosis ☐ Numbness / Tingling ☐ Seizures ☐ Weakness	☐ Chest Pain ☐ Heart Murmur ☐ High Blood Pressure ☐ Pacemaker ☐ Heart Attack	☐ Bleeding Tendency ☐ Blood Clotting Problem ☐ Hepatitis ☐ HIV / AIDS ☐ Swollen Glands
	Eyes	**Gastrointestinal**	
	☐ Blurred Vision ☐ Cataracts ☐ Double Vision ☐ Frequent Dry Eyes ☐ Glaucoma ☐ Pain	☐ Abdominal Pain ☐ Indigestion / Heartburn ☐ Liver Disease ☐ Nausea or Vomiting ☐ Special Diet ☐ Stomach Ulcers	

Family Medical History

Has anyone in your family ever had:

Uncontrolled bleeding	☐ Yes	☐ No	Problems with anesthesia	☐ Yes	☐ No
Bleeding clotting issues	☐ Yes	☐ No	Malignant Hyperthermia	☐ Yes	☐ No

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Breast Consultation Information

Current Bra Size:	Desired Bra Size:	Height:	Weight:

Do you Smoke: ☐ Yes ☐ No If Yes, how many packs per day ________ How many years ________

Breast Cancer History

Have you ever had a mammogram? ☐ Yes ☐ No
If so, when was your most recent mammogram:
Date: ____________________
Facility: ____________________
Was the mammogram normal? ☐ Yes ☐ No
If abnormal, what was found? ____________________
____

Have you had breast cancer? ☐ Yes ☐ No
Any family members with breast cancer? ☐ Yes ☐ No
If so, please least which relative(s): ____________
Relationship: ____________________
Breast Biopsies: ____________ ☐ Yes ☐ No
Age at First Period ____________________
Pregnancies: # ____________ Live Births: ____________
Hormone Replacement or Birth Control: ____________

FOR OFFICE USE ONLY BELOW THIS LINE
****

MEASUREMENTS	RIGHT	LEFT
SN-N		
N-IMF		
BASE WIDTH		
ESTIMATION OF GRAMS		

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Release of Information Request

Patient Name: ______________________________ Patient DOB: ______________

Address: ________________________ City: ____________ State: ____ Zip: ________

I, ______________________ authorize Dr. M'liss Hogan, M.D.

to receive information concerning my care, in accordance with state and federal laws, from the following:

Name/Organization: ________________________

Address: ________________________

Phone #: ________________________

Fax #: ________________________

Specific information to be disclosed (*check all that apply)*

___ Lab Reports ___ Radiology/X-Ray Reports ___ Radiology/X-Ray Films/Discs

___ EKG/Stress Test ___ History & Physical Exam ___ Progress Notes

___ Consult Reports ___ OP Procedure Reports ___ Emergency Room Records

___ D/C Instructions ___ D/C Summary ___ Other: ________________________

X ____ Date: ______________
(Patient's Signature)

X ____ Date: ______________
(Witnesses Signature)

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HIPPA Authorization Form for Family Members/Friends

I, ______________________________, give permission to all my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name(s):	Relationship:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Health Information to be disclosed (Check all that apply):

- ○ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing for all conditions) OR
- ○ My complete health record, as above, with the exception or the following information: (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify) ______________________________

    ____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event: ______________________________

  Unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferable in writing.)

____
Name of the Individual Giving this Authorization

______________________________ ______________________________
Signature of the Individual Giving this Authorization Date

Patient Rights

As a Patient you have the right to:

1. Considerate, respectful care at all times and under all circumstances with recognition of your personal dignity.
2. Personal and informational privacy within the law.
3. Information concerning your diagnosis, treatment and prognosis, to the degree known; confidentiality of records and disclosures. Except when required by law, you have the right to approve or refuse the release of records.
4. Sale of Private Health Information (PHI) is prohibited.
5. It is the duty of the organization to notify any patient of a breach of unsecured Private Health Information (PHI).
6. The patient has the right to restrict disclosure of PHI where the patient paid "out of pocket".
7. The opportunity to participate in decisions involving your health care unless contraindicated by concerns for your health.
8. Make decisions about medical care including the right to accept or refuse medical or surgical treatment and the right to initiate advance directives such as a living will or durable power of attorney. If you already have a living will or other directive or you wish to initiate one, please speak with a nurse.
9. Information concerning implementation of any advance care directive.
10. Impartial access to treatment regardless of race, color, sex, national origin, handicap or disability. The Center adheres to all federal and state rules, regulations and policies to promote a nondiscriminatory environment for all of our surgical guests.
11. Receive an itemized bill for all services.
12. Know the identity and professional status of individuals providing services to you.
13. Report any comments concerning the quality of services provided to you during the time spent at the facility and receive fair follow-up on your comments.
14. Choose which facility you have your procedure performed.

Patient Responsibilities

As a patient, you are responsible for:

1. Providing to the best of your knowledge accurate and complete information about your present health status and past medical history and reporting any unexpected changes to the appropriate practitioner(s).
2. Following the treatment plan recommended by the primary practitioner involved in your case.
3. Providing for an adult to transport you home after surgery and an adult to be responsible for you at home for the first twenty-four (24) hours after surgery.
4. Indicating whether you clearly understand a contemplated course of action and what is expected of you.
5. Your actions if you refuse treatment, leave the facility against, the advice of the practitioner, and/or not follow the practitioner's instructions relating to your care.
6. Assuming that the financial obligations of your health care are fulfilled as expediently as possible.
7. Providing information about and/or copies of any living will, power of attorney or other directive that you desire us to know about.

I have read and understand my rights and responsibilities as a patient of Dr. Hogan.

_______________________________ _______________

Patient Signature Date