PAUL L. PROFFER, MD, FACS, PA
1611 Wallace Blvd.
AMARILLO, TX 79106
(806) 355-3532

Patient's Full Name: __________________________ Name Preferred to be Called: ____________________ Sex: _____ Race: _______
Street Address: _________________City:_______ State: _____ Zip: ____ Home #: (____) __________ Cell #: (____) ____________
Birth Date: _________________ Age: ________ Social Security No: ____
E-Mail Address: ____

Marital Status: (circle) M S W D Spouse's Name: ____
Spouse's Social Security No: _____________________________________ Spouse's Birth Date: ______________________________

Responsible Party (if different than patient or spouse):____
Address: ____ City/State/Zip: ____
Social Security No: _____________________ Birth Date: ________________ Relationship to patient: ___________________________
Responsible Party Home Phone: (____) __________________________ Cell Phone: (____) ___________________________________

If Referred By Another Physician – Physician Name: ____
Address: ____ City/State/Zip: ____
Phone: (____) ____

Primary Care Physician (if different from referring Physician):____
Address: _________________________________ City/State/Zip: _________________________Phone #_________________________

Primary Insurance Company Secondary Insurance Company

Primary Insurance Company	Secondary Insurance Company
Name: ____	Name: ____
Address: ____	Address: ____
City/State/Zip: __________________________________	City/State/Zip: _______________________________________
ID Number: _____________________________________	ID Number: ____
Subscriber: _____________________________________	Subscriber: ____
Subscriber Social Security No: _____________________	Subscriber Social Security No: _________________________
Subscriber DOB: ________________________________	Subscriber DOB: _____________________________________

Patient's Employer: ____ (Full time______) (Part time______) (Retired_______):
Address: ____ City/State/Zip: ____
Work Phone: (____) _______________________________________

Spouse's (or Responsible Party's) Employer (or retired from):____
Address: ____ City/State/Zip: ____
Work Phone: (____) _______________________________________

Emergency Contact: ___________________________________ Relationship: ____
Address: ____ City/State/Zip: ____
Phone: (____) ____ Cell Phone: (____) ____

REASON FOR VISIT: ____
DATE OF INJURY: ____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION BY PROFFER SURGICAL ASSOCIATES, LLP FOR ANY INSURANCE CLAIMS SUBMISSION AND AT THE DOCTOR'S DISCRETION, ASSIGN THE INSURANCE PAYMENT TO THEMFOR THESE SERVICES, I UNDERSTAND THAT I AM FINANCILLY RESPONSIBLE FOR THE CHARGES THAT ARE NOT COVERED.

- **PATIENT OR RESPONSIBLE PARTY SIGNATURE:** _______________________ **DATE:** ____________________
- **PREFERRED PHARMACY:** ____ **PHONE:** ___________________

Have you been hospitalized in the last five years? ___ Yes ___ No. If yes: what for: ____
____

Current Height: _______________ Current Weight: ________________

Do you have a pacemaker or defibrillator? Yes ___________ No ____________

Have you had a diabetic eye exam recently? Yes □ No □ If yes, when and where: ____

SURGICAL HISTORY INCLUDING EYE SURGERIES

Date	Type of Surgery

MEDICAL HISTORY

Personal Medical History: Have you ever had or do you now have: (Check YES or NO)

	YES	NO		YES	NO
Shortness of breath			Excessive scarring		
Chest or heart pain / angina			Stomach or duodenal ulcer		
Asthma			Vomiting blood / black stools		
Chronic bronchitis			Recent gain or loss in weight		
Frequent colds / cough			Herpes or fever blisters		
Heart disease or heart attack			Hernia (groin or abdominal)		
High or low blood pressure			Kidney trouble or nephritis		
Breast problems / disease			Painful or bloody urination		
Rheumatic fever			Low back trouble / back ache		
Ankle swelling			Varicose veins		
Easy bruising			Dizziness		
Excessive bleeding			Radiation therapy		
Anemia or blood disease			Epilepsy or seizures		
Thyroid disease			Emotional / psychiatric problems		
Sugar or albumin in urine			Frequent or severe headaches		
Diabetes			AIDS or HIV		
Skin cancer			Facial paralysis or numbness		
Arthritis / joint problems			Limited activity		
Chronic diarrhea / bowel trouble			Anesthesia problems		
Hepatitis / jaundice / liver trouble					

SMOKING HISTORY Do you smoke/vape Yes □ No □
If so, how long have you smoked/vaped:____________________
If so, how may packs per day: ________________________
____
If quit, how long ago: ______________________________
Do you take illicit drugs? ____________________________

ALCOHOL SCREENING:
Did you have a drink containing alcohol in the past year: Yes □ No □
If yes: How often did you have six or more drinks on one occasion in the past year? ____
How many drinks did you have on a typical day when you were drinking in the past year?
How often did you have a drink containing alcohol in the past year?
____

Have you had a pneumonia vaccine? Yes □ No □ If yes, when and where: ____
Have you had a flu vaccine? Yes □ No □ If yes, when and where: ____

Other physical conditions: ____

Family History:

____

____

Are you receiving other health care? Yes □ No □ If so, please indicate the nature of the care: ________________________

____

Name of Primary Care or Other Physician: ____________________ Address: _____________________________________
Phone #: ____

Name of Cardiologist: ______________________________________ Phone Number: ____________________________

**** Patient Name (print) : ____**

**** Patient Signature: _____________________________Date: ________________**

Please list ALL drug allergies and reactions

Medication	Reaction

Please list ALL medications, vitamins and over-the-counter medications taken:

Medication	Dosage	Frequency	Reason for Taking

Patient Name: ____ **Date:** ___________________

Continue listing meds

Medication	Dosage	Frequency	Reason for Taking

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, the undersigned patient consent to the following, photographs and/or videos of me to be used by Proffer Surgical Associates.

I consent to such photographs, videos and any associated quotes by me being edited and published by my Doctor and/or any party acting under my Doctor's license and authority in any print or electronic form, including, but not limited to posts on social media, for the purpose of informing the medical profession or the general public about aesthetic procedure methods and results, surgical and non-surgical, and whether or not such settings are regarded as educational, scientific of commercial.

I expect to be recognized from my likeness or quotes.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will exist in perpetuity from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from my Doctor.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I release and discharge my Doctor and all parties acting under my Doctor's license and authority from all rights that I may have in the photographs, videos or quotes and from my claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these material in any medium. I certify that I have read the above Authorization and Release and fully understand its terms.

______________________________ ______________________________

Patient Signature Witness / Physician

______________________________ ______________________________

Printed Patient Name Date

I have read the above Authorization and Release. I am the parent, guardian or conservator of the patient, a minor. I am authorized to sign this consent on the patient's behalf.

______________________________ ______________________________

Patient/Guardian/Conservator Signature Date

____

Printed Patient/Guardian/Conservator Name

Proffer Surgical Associates

ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgment.

I ___________________________________ have received a copy of this office's Notice of Privacy Practices. *You have the right to refuse to sign this document*

____

(Please Print Name)

____

(Signature)

Date: ____

I give permission to release medical information to the following persons:

Name: ________________________ Relationship: _____________ Phone: _________
Name: ________________________ Relationship: _____________ Phone: _________
Name: ________________________ Relationship: _____________ Phone: _________

<u>Office Use Only</u>

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

_____ The patient or individual refused to sign this document

_____ Communications conflicts prohibited us from obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please specify) ____

____

Marketing Authorization Form

Patient Name: ______________________________ Date: ________________________________

1. Authorizing marketing communication from this practice means I may:
   a. Receive treatment communications concerning treatment alternatives or other health related products or services.
   b. Be contacted for appointment reminders or information about treatment alternatives or other health related benefits and services that may interest me.

- **I understand that I have the right to "opt out" of receiving such communications.**
- **I understand that this practice may receive remuneration for communications.**

Other communications for such purposes that do not involve financial remuneration are adequately captured in this practice's notice of privacy practices (NPP).

2. Marketing Authorization Options:

□ **I wish to receive Marketing Communications from this Practice Only.**
□ **I wish to receive Marketing Communications from this Practice, and this Practice's Business Associates.**
□ **I do NOT wish to receive any Marketing Communications.**

Patient Signature: ____

Communication that encourages you to use our services is considered marketing. If we intend to use, or sell PHI for personal gain or commercial advantage, we must **first obtain written authorization.** Authorization is required for all treatment and health care operations communications where the covered entity receives financial remuneration for making the communications for a third party whose product or service is being marketed. Such a policy will ensure that all such communications are treated as marketing communications, instead of requiring covered entities to have two processes in place based on whether the communication provided to individuals is for a treatment or a health care operations purpose. **We MAY receive financial remuneration from a third party due to marketing.**

HIPAA states the term "financial remuneration" does not include non-financial benefits, such as in-kind benefits, provided to a covered entity in exchange for making a communication about a product or service. Rather, financial remuneration includes only payments made in exchange for making such communications.

In addition, HIPAA emphasizes that the financial remuneration a covered entity receives from a third party must be for the purpose of making a communication and such communication must encourage individuals to purchase or use the third party's product or service. If the financial remuneration received by the covered entity is for any purpose other than for making the communication, then this marketing provision does not apply.

Provided by Compliance PhD