PATRICK J. PROFFER, M.D.
1611 Wallace Blvd.
AMARILLO, TX 79106
(806) 352-1185

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Patient's Full Name:_____________________________ Name Preferred to be Called: ____________Sex: _______
Street Address:____________________________________________________ Race:__________________________
City:___________________ State: __________ Zip:____ Home Ph: (____)__________ Cell Ph: (____)__________
Birth Date: _____________________ Age: ________ Social Security No: __________________________________
Marital Status: (circle) M S W D Spouse's Name:_____________________________________________________
Spouse's Social Security No: _________________________ Spouse's Birth Date:__________________________
E-Mail Address:___________________________________________________________________________________

Responsible Party (if different than patient or spouse):_____________________________________________________
Address:_____________________________________________City/State/Zip:________________________________
Social Security No:_______________________ Birth Date:_____________ Relationship to patient:_______________
Responsible Party Home Ph: (____)__________ Cell Ph: (____)__________

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**
Name: __________________________________________
Address:_______________________________________
City/State/Zip:__________________________________
ID Number:_____________________________________
Subscriber:______________________________________
Subscriber Social Security No:____________________
Subscriber DOB:_________________________________

**Secondary Insurance Company**
Name:___________________________________
Address:________________________________
City/State/Zip:___________________________
ID Number:______________________________
Subscriber:______________________________
Subscriber Social Security No:_____________
Subscriber DOB:__________________________

Patient's Employer (or retired from):_______________________________________________________________
Address:____________________________________________ City/State/Zip:________________________________
Work Ph: (____)__________

Spouse's (or Responsible Party's) Employer (or retired from):____________________________________________
Address:____________________________________________ City/State/Zip:________________________________
Work Ph: (____)__________

Emergency Contact:_____________________________ Relationship:______________________________
Address:_______________________________________ City/State/Zip:____________________________
Phone: (____)__________ Cell Ph: (____)__________

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 THEM FOR THESE SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES THAT ARE NOT COVERED.

PREFERRED PHARMACY___________________________________________________________________________
PHONE:______________________________________________________________________________________

PATIENT OR RESPONSIBLE PARTY
SIGNATURE:____________________________________________________________DATE:___________________

**REASON FOR VISIT**________________________________________ **DATE OF INJURY**__________________

Height ________________ Weight ________________ Are you currently, or could you be pregnant? ______________________
Are you right or left handed?______________________ Do you have a pacemaker or defibrillator: ______________________________

## PAST AND CURRENT MEDICAL CONDITIONS

BREAST HISTORY (If applicable)
Have you had previous breast surgery? Yes □ No □ If so, what type? ________________________________________
Do you have a history of breast cancer in your family? ________________________________________
If so, who and at what age? ________________________________________
When was your last mammogram? ________________________________________
Any concerns or abnormalities? ________________________________________
If you had children, did you breast feed? ________________________________________

| Medications now taking or have taken in the last month (including doses) | DRUG ALLERGIES | OTHER ALLERGIES |
|---|---|---|
| | | |
| | | |
| | | |

| Herbal Supplements / Vitamins (including doses) | |
|---|---|
| | |
| | |

| PREVIOUS SURGERIES / DATES: | |
|---|---|
| | |
| | |

SMOKING HISTORY Do you smoke or vape Yes □ No □
If so, how long have you smoked? ____________________________
If so, how much?___________ If quit, how long ago?__________

ALCOHOL OR ILLICIT DRUG USE Do not use □
Less than 6 per week □ 6 or more per week □
Type ________________________________________________

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

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| 1. SHORTNESS OF BREATH | | | 22. EXCESSIVE SCARRING | | |
| 2. CHEST OR HEART PAIN/ANGINA | | | 23. STOMACH OR DUODENAL ULCER | | |
| 3. ASTHMA | | | 24. VOMITING BLOOD/BLACK STOOLS | | |
| 4. CHRONIC BRONCHITIS | | | 25. RECENT GAIN OR LOSS IN WEIGHT | | |
| 5. FREQUENT COLDS/COUGH | | | 26. HEMORRHOIDS | | |
| 6. HEART DISEASE OR ATTACK | | | 27. HERNIA (GROIN OR ABDOMINAL) | | |
| 7. HIGH OR LOW BLOOD PRESSURE | | | 28. KIDNEY TROUBLE OR NEPHRITIS | | |
| 8. HEART VALVE PROBS/MURMURS | | | 29. PAINFUL OR BLOODY URINATION | | |
| 9. BREAST PROBLEMS/DISEASE | | | 30. LOW BACK TROUBLE/BACKACHE | | |
| 10. RHEUMATIC FEVER | | | 31. VARICOSE VEINS | | |
| 11. ANKLE SWELLING | | | 32. BLOOD CLOTS | | |
| 12. EASY BRUISING | | | 33. RADIATION THERAPY | | |
| 13. EXCESSIVE BLEEDING | | | 34. EPILEPSY OR SEIZURES | | |
| 14. ANEMIA OR BLOOD DISEASE | | | 35. EMOTIONAL/PSYCHIATRIC PROBLEMS | | |
| 15. THYROID DISEASE | | | 36. FREQUENT OR SEVERE HEADACHES | | |
| 16. SUGAR OR ALBUMIN IN URINE | | | 37. AIDS OR HIV | | |
| 17. DIABETES | | | 38. FACIAL PARALYSIS OR NUMBNESS | | |
| 18. SKIN CANCER | | | 39. LIMITED ACTIVITY | | |
| 19. ARTHRITIS/JOINT PROBLEMS | | | 40. ANESTHESIA PROBLEMS | | |
| 20. CHRONIC DIARRHEA/BOWEL TRB. | | | 41. HERPES OR FEVER BLISTERS | | |
| 21. HEPATITIS/JAUNDICE/LIVER TRB. | | | | | |

Please list any other medical conditions: ________________________________________________
________________________________________________________________________

Patient Signature__________________________________________ Date ______________________________

## 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

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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: _________

**Office Use Only**

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*