Kimberly A. Pummill, M.D.
Grand Blanc Plastic Surgery

Patient Registration

Patient's name_____ Sex____ Age_____ Birthdate_____
Address_____City_____State_____Zip_____
Social Security Number _____ Marital Status_____
Home Ph: ( )_____Cell Ph:( )_____Other Ph: _____
Is it okay to leave a message at the above phone numbers given? Y N
Race: _____ Preferred Language: _____
Email:_____Ethnicity: Please circle one: Hispanic/Latino
NOT Hispanic/Latino

Family Doctor_____
Family Doctor Address_____
Family Doctor Phone Number ( )_____
Preferred pharmacy:_____ Phone :_____
Pharmacy city and zip: _____

In case of emergency, please contact_____
Relationship_____ Home Phone ( )_____
Work Phone ( )_____Other Phone ( )_____

Employer_____Occupation_____
Employer Address_____City_____State_____Zip_____
Work Phone ( )_____ Ext _____ Is it okay to call you at work? Y N

Who referred you to this office? _____

Primary Insurance Information

Insurance Company_____
Address _____City_____ State_____ Zip_____
Policy/Contract #_____Group Number_____Copay $_____
Policy Holder_____Relationship to patient_____ Birthdate_____

Secondary Insurance Information

Insurance Company_____
Address _____City_____ State_____ Zip_____
Policy/Contract #_____Group Number_____Copay $_____
Policy Holder_____relationship to patient_____ Birthdate_____

Health History

Why are you seeking treatment? _____
Previous Treatment_____ Date of Injury_____

Medications:

List all known drug allergies: _____

List all medications you are taking, or have taken in the last 6 months. Include inhalers, patches, and non-prescription medications:_____

Operations and Hospitalizations: List all prior operations and medical problems for which you have been hospitalized. Give approximate year of occurrence.

_____

_____

Please answer each question. Circle yes or no. If in doubt, leave blank.

1. Have you ever had excessive bleeding ? Y N
2. (Women) Are you pregnant? If so, give due date _____ Y N
3. Do you use tobacco in any form? If yes, how much? _____ Y N
4. Do you use alcoholic beverages (More than 2 per day?) Y N
5. Do you have, or have had any of the following?

General			**Heart/Blood Vessels**		
Tire easily, weakness	Y	N	Heart Murmur	Y	N
Marked weight change	Y	N	Chest pain/angina	Y	N
Fever/Chills	Y	N	Heart attack/failure	Y	N
Skin			Shortness of breath	Y	N
Hives	Y	N	Mitral Valve Prolapse	Y	N
Skin Changes	Y	N	High Blood Pressure	Y	N
Eyes			Pacemaker	Y	N
Visual Changes	Y	N	Irregular Heart Beat	Y	N
Glaucoma	Y	N	**Bone/Muscles**		
Nose			Arthritis	Y	N
Frequent nosebleeds	Y	N	Back Pain	Y	N
Sinus problems	Y	N	**Digestive System**		
Throat			Hepatitis	Y	N
Soreness/hoarseness	Y	N	Jaundice	Y	N
Nervous System			Ulcers	Y	N
Stroke	Y	N	Cirrhosis/liver disease	Y	N
Headaches	Y	N	**Urinary**		
Convulsions/epilepsy	Y	N	Kidney disease	Y	N
Dizziness/fainting	Y	N	**Blood**		
Weakness/numbness	Y	N	Anemia/Sickle cell	Y	N
Respiratory			Bruise easily	Y	N
Tuberculosis	Y	N	Blood transfusion	Y	N
Emphysema	Y	N	High cholesterol	Y	N
Asthma	Y	N	Diabetes/high sugar	Y	N
Bronchitis	Y	N	Low blood sugar	Y	N
Other					
Cancer	Y	N			
Thyroid disease	Y	N			

To the best of my knowledge, all of the proceeding answers are true and correct.
If I ever have a change in my health or a change in my medications, I will inform the doctor at my next appointment.

Signature of patient, parent, or guardian:

_____ *Date:* _____

Kimberly A. Pummill, M.D., P.C.
8384 Holly Rd. Suite 1
Grand Blanc, MI 48439
Phone: (810) 606-7888
Fax: (810) 606-6864

Patient Consent for Medical Treatment

Name_____ Birth Date _____

I hereby request and authorize, now and anytime in the future, any type of medical services Kimberly A. Pummill, M.D., her assistants or designees advise. These include routine history and physical examinations, routine diagnostic radiology and laboratory procedures, therapeutic procedures, drugs, and routine medical care pertaining to Dr. Pummill's specialty of Plastic and Reconstructive Surgery. I understand that in emergencies it may be necessary to expand or deviate from the services listed here in order to preserve my life or health, and I consent to these expanded services and procedures.
Dr. Pummill has made no guarantees or assurances about the results of my treatment. I understand that I will receive the usual and ordinary care rendered in this community, and that no other contract, written, verbal, or implied, is made.

Patient Consent for Photographing, Filming, Recording, or Televising

In connection with the medical services I am receiving from my physician, Dr. Kimberly A. Pummill, M.D., I consent that photographs, films, or recordings may be taken of me or parts of my body, and I further consent to the televising of any treatment provided to me, or procedures or operations performed upon me by Dr. Pummill, under the following conditions:

1. The photographs, films or recordings may be taken only with the consent of Dr. Pummill and under such conditions and at such times as may be approved by her.
2. The photographs, films or records shall be taken by Dr. Pummill or a photographer or technician approved by her, and I authorize such photographer or technician to be present during my treatment
3. The photographs, films, or recordings shall be used for medical records and, if in the judgment of Dr. Pummill, medical research, education, or science will benefit by their use, such photographs, films, recordings, and information relating to my case or treatment may be published in professional journals or medical books, and may be televised or used for any other purpose which Dr. Pummill may deem proper in the interest of medical education, knowledge, or research, including use during lectures; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name.
4. I hereby grant permission for the use of any record, illustration, photograph or other imaging record created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.
5. I waive all rights that I may have to any claims for payment or royalties in connection with any exhibit, publication, televising, or other showing of any photograph, film, or recording. I grant this consent as a voluntary contribution in the interest of medical education and knowledge.

Statement of Financial Responsibility

Dr. Pummill participates with Medicare, Worker's compensation and some other insurance programs. However, Dr. Pummill does not participate with every insurance program, and may not participate with yours. Some insurance programs require that you only see certain physicians and will allow payment of non-approved physicians only with specific written permission from the insurance program. In addition, coverage varies among insurance programs. I understand that I am responsible for submitting claims to insurance programs which Dr. Pummill does not participate with for any non-surgical service (i.e. office visits, x-rays, etc.) provided to me by Dr. Pummill. As a courtesy, Dr. Pummill will submit claims for payment for surgical procedures to your insurance programs, even if Dr. Pummill does not participate with that program. If my insurance company pays me directly for such claims, I agree to immediately endorse the check and remit it directly to Dr. Pummill.

I agree personally to pay for any and all charges incurred by me during the course of my medical care, including charges not covered by or collected from my health care insurance or benefit program, including any deductibles and co-insurance amounts. If my insurance program pays me directly for any services rendered by Dr. Pummill, I agree to immediately endorse the check and remit it directly to Dr. Pummill.

PLEASE READ THIS AGREEMENT CAREFULLY BEFORE SIGNING, AND LET US KNOW IF YOU HAVE ANY QUESTIONS. YOU ARE RESPONSIBLE FOR WHAT YOU SIGN.

Date: _____ _____

(Signature of patient, parent (if patient is a minor), or legal guardian.

Kimberly A. Pummill, M.D., P.C.
8384 Holly Rd. Suite 1
Grand Blanc, MI 48439
Phone: (810) 606-7888
Fax: (810) 606-6864

Medical Records Release of Information

I authorize you to release information from my medical record (or from the medical record of _____, including:
(insert name of patient)

- Information about communicable diseases and serious communicable diseases and infection as defined by statute and Michigan Department of Public Health rules (which include venereal disease ("VD"), tuberculosis ("TB"), human immunodeficiency virus ("HIV"), acquired immunodeficiency syndrome ("AIDS") and AIDS related complex ("ARC").
- Substance abuse treatment information protected by 42 Code of Federal Regulation Part 2.
- Psychological and social service information, including communications made by me to a psychologist or social worker.

To my physician_____, and any third party payer or insurance company (including Medicare, Medicaid, Blue Cross/Blue Shield, commercial health insurers, automobile no-fault insurers, worker's disability compensation insurers, health maintenance organizations, preferred provider organizations, and managed care plans) which are responsible in whole or in part for paying my medical bills so that Dr. Pummill may be paid for her services.

To: Kimberly A. Pummill, M.D.
(Name)
At: 8384 Holly Rd. Suite 1
(Street address)
Grand Blanc, MI 48439
(City, State)

_____
(Signature of patient, parent (if patient is a minor), or legal guardian.

Date:_____

Kimberly A. Pummill, MD, PC
8384 Holly Rd. Suite 1
Grand Blanc, MI 48439
Phone: (810) 606-7888
Fax: (810) 606-6864

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, _____, have been given the opportunity to review the Notice of Privacy Practices as provided by Kimberly A. Pummill, MD, PC. I have also been given the opportunity to ask questions pertaining to this agreement. My signature on this form indicates that I have reviewed this Notice and that this Notice has been explained to me in a manner that I understand.

_____

Patient or Person Authorized to Sign for Patient

Date_____ Witness _____

In order to protect the privacy of you and your dependants, please list to whom, if anyone, we may inform about your general medical condition and diagnosis:

Name: Relationship:

Name:_____Relationship:_____

Name:_____Relationship:_____