PATIENT DEMOGRAPHICS

Preferred Name: **Legal Name:**			
First	*Middle*	*Last*	
Address:			
Street & Apt #	*City*	*State*	*Zip*

Marital Status: ☐ Single ☐ Married ☐ Other	**SSN:**	**DOB:**	**Sex:** ☐ Male ☐ Female
Race: ☐ African-American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ White			
Ethnicity: ☐ Hispanic ☐ Non-Hispanic		**Pref. Language:**	
Home Phone: ☐ I give permission to Dr. J. J. Wendel Plastic Surgery to leave a voicemail at this number.	**Work Phone:** ☐ I give permission to Dr. J. J. Wendel Plastic Surgery to leave a voicemail at this number.	**Cell Phone:** ☐ I give permission to Dr. J. J. Wendel Plastic Surgery to leave a voicemail and/or text me at this number.	
Email: ☐ I give permission to Dr. J. J. Wendel Plastic Surgery to email me at this email.	**Preferred Method of Contact:** ☐ Home ☐ Work ☐ Cell ☐ Email ☐ Text	**Any Restrictions to Contact (including mail):** ☐ Yes ☐ No If yes, describe_____	
Employer:		**Occupation:**	
Emergency Contact:	**Relationship to Patient:**	**Phone:**	
How did you hear about us? ☐ Doctor* ☐ Friend* ☐ Insurance ☐ Internet Search ☐ Social Media ☐ Other: *Who referred you?:			
Preferred Pharmacy Name:	**Preferred Pharmacy Phone:**	**Preferred Pharmacy Address:**	

Insurance Information		
Primary Insurance:	**Primary Policy Holder Name:**	**Primary Policy Holder Employer:**
Relation to Patient:	**Primary Policy Holder DOB:**	**Primary Policy Holder SSN:**
Secondary Insurance:	**Secondary Policy Holder Name:**	**Secondary Policy Holder Employer:**
Relation to Patient:	**Secondary Policy Holder DOB:**	**Secondary Policy Holder SSN:**

Responsible Party *(If Patient is a Minor)*	
Name:	**Address:**
Relation to Patient:	**DOB:**

Privacy Practices Notice & Written Acknowledgement Form

I have been offered a copy of Dr. J. J. Wendel Plastic Surgery Notice of Privacy Practices.

Signature of Patient / Guardian: **Date:**

INSURANCE FINANCIAL POLICY

- I understand that Dr. J. J. Wendel Plastic Surgery accepts the following forms of payment: all major debit/credit cards, cash, cashier's check, Care Credit (accepted promotional plans vary), for insurance procedures or office visits: flexible spending account (FSA), health savings account (HSA), health reimbursement arrangement (HRA), and personal checks from established surgery patients only.
- I agree to furnish Dr. J. J. Wendel Plastic Surgery with a copy of my current health insurance card(s). I also agree to provide an explanation of benefits and/or claim form(s) from my insurance company, when applicable.
- I authorize the release of medical information necessary to process my insurance claim and I assign insurance benefits to Dr. J. J. Wendel Plastic Surgery for services provided to me by Dr. J. J. Wendel Plastic Surgery.
- I understand that co-pays are due at the time of service, as required by my insurance company.
- I agree that I will be responsible for balances applied to my account that are not covered by my health insurance plan.
- In the event my account is turned over to an outside collection agency, I agree to pay all cost of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35%, such contingency fee to be added and collected by the collection agency immediately upon my default and the referral of my account to said collection agency.
- I understand that my account will be charged $40 when a check I presented for payment is returned and marked "non-sufficient funds" (NSF). Returned checks over $500 will be assessed a fee of 5% of the amount of the check.
- I understand that Dr. J. J. Wendel Plastic Surgery will bill my health insurance company and will refund any overpayment on my account to the appropriate party (e.g., insurance company or patient).
- I understand that Dr. J. J. Wendel Plastic Surgery allows 30 days for the processing of my claim by the insurance company. In the event the practice does not receive reimbursement within 45 days, they will contact my insurance company regarding the claim.
- Any co-insurance, deductible, out of pocket and co-pay amounts will be my responsibility. Any balance after insurance has paid must be remitted within 30 days or my balance is subjected to a monthly interest charge which will be applied to my account of $10 or 10% whichever is greater. In the event I am unable to pay my responsibility in full, I will contact your office to discuss financial arrangements.
- I understand that Dr. J. J. Wendel Plastic Surgery has a no-show fee of $200. If I have been quoted and scheduled for a procedure, I understand that the deposit, as outlined on the quote, is considered the no show fee.
- In the event I need to cancel or reschedule my appointment, I understand that Dr. J. J. Wendel Plastic Surgery requires 48 hours' notice. If I cancel or reschedule my appointment without proper notice as outlined above, I will incur a cancellation fee of $200. If I have been quoted and scheduled for a procedure, I understand that the deposit, as outlined on the quote, is considered the cancellation fee.
- Unless seen by Dr. J. Jason Wendel in the Emergency Department, I understand that Dr. J. J. Wendel Plastic Surgery will not submit to Motor Vehicle Accidents (MVA) or Third Party Liability. I will be held responsible for payment in full at time of service. If I was seen by Dr. J. Jason Wendel in the Emergency Department, to submit to Motor Vehicle Accidents (MVA) or Third Party Liability: the following is required: claim detail (claim#, contact info, billing address) at the time of my appointment. If required information is not presented the time of my appointment, payment in full is required for MVA or other accident-related injury. We will file claim(s) with the motor vehicle or third party insurance company that you designate, provided we receive all necessary information. If the claims are denied, or a protracted lawsuit is involved, the patient is responsible to pay the account balance in full. We will bill your private health insurance for balance left after your personal injury protection (PIP) is exhausted.
- I have read, understand, and agree to the insurance assignment and financial policies stated above. I also agree that I have had the opportunity to discuss any questions or concerns regarding the above with the Insurance Specialists at the practice.

COLLECTIONS

Customer, patient, borrower, etc. agrees to pay all cost of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35%, such contingency fee to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency.

Signature of Patient/Guardian: **Date:**

Print Name of Patient/Guardian:

AUTHORIZATION OF PAYMENT & RELEASE OF INFORMATION

I request payment of authorized insurance benefits be paid to Dr. JJ Wendel Plastic Surgery. & authorize release of medical information as needed to determine payable benefits for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature of Patient/Guardian: **Date:**

Print Name of Patient/Guardian:

FINANCIAL POLICY

I have received and agree to Dr. J. J. Wendel Plastic Surgery Financial Policy.

Signature of Patient/Guardian: **Date:**

Print Name of Patient/Guardian:

RELEASE & CONSENT TO PHOTOGRAPH & PUBLISH

Clinical / Medical Consent (REQUIRED for Clinical Documentation)

I grant my permission for the use of photographs, videos or case information for the following clinical purposes as indicated by my initials below:

_____ **(initial)** I understand that these photographs, videos or case information are for clinical use and review by Dr. J. J. Wendel Plastic Surgery.

_____ **(initial)** I understand that these photographs, videos or case information may be submitted to my insurance company for precertification purposes and for processing insurance claims.

_____

Name of Patient or Parent/Guardian (Please Print)

_____

Signature of Patient or Parent/Guardian

_____

Date

Marketing / Educational Consent (Optional)

High quality before and after photos help others select a qualified and experienced medical practice.
Dr. J. J. Wendel Plastic Surgery is pleased to participate in digital media outlets such as Facebook, Instagram, RealSelf, Yelp, and our website (www.drjjwendel.com). Through these online venues, we share staff pictures, office updates, contests, and other fun and helpful information. With the expressed permission of our patients, we are pleased to share photos of their beautiful results that may help those seeking a qualified, exceptional plastic surgeon or aesthetic provider.

Please initial one of the following:

_____I give my consent to allow Dr. J. J. Wendel Plastic Surgery to post photographs of me online.

_____I do not give my consent to my photographs being shared online.

_____

Name of Patient or Parent/Guardian (Please Print)

_____

Signature of Patient or Parent/Guardian

_____

Date

PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION

Patient's Full Name:	**DOB:**
Patient's Address:	
Street & Apt # *City State Zip*	
Preferred Phone Number:	

I give permission to Dr. J. J. Wendel Plastic Surgery to verbally discuss the information about me marked below (check all that apply):

- ☐ Scheduling / Appointment information.
- ☐ Medical information, including symptoms, diagnosis, medications, and treatment plans.
- ☐ Information about sexually transmitted disease (STD) testing and treatment, including HIV/AIDs testing and treatment.
- ☐ Information about pregnancy tests, abortions services, prenatal care, and birth control.
- ☐ Mental health information, including symptoms, diagnosis, medications, evaluations and treatment plans.
- ☐ Chemical dependency information, including symptoms, diagnosis, medications, and treatment plan.

Substance Use Disorder information requires a separate signed written authorization.

- ☐ Educational history and evaluations, including Individualized Educational Plans.
- ☐ Referrals for services requested and/or recommended by my providers, including appointment information.
- ☐ Billing and payment information
- ☐ Other (describe): _____

Dr. J. J. Wendel Plastic Surgery may discuss the above information about me with (optional):

Name	Phone Number	Relationship to Patient

I understand that I do not have to sign this form. The information will be shared to help coordinate my health care. I understand this form may be used to discuss information related to my health care. Any release of substance use disorder information must be in accordance with 42 C.F.R. Part 2. **I understand if I do not sign this form, then Dr. J. J. Wendel Plastic Surgery will not be able to discuss my information with the people listed on this form.**

I understand I may cancel this permission at any time (by writing to Dr. J. J. Wendel Plastic Surgery). Cancelling it will not impact any information that has already been discussed. **This form is valid until I cancel it.**

Signature of Patient/Guardian: _____ Date: _____

If signed by authorized representative, attach copies of supporting legal documentation. Note: A minor patient's signature is REQUIRED to share information about: 1. STD/HIV/AIDs, pregnancy, abortion, prenatal care, and birth control 2. Mental health treatment 3. Substance abuse treatment.

PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION

Dr. J. J. Wendel Plastic Surgery must follow privacy laws that impact sharing your health information. We want to make it easy for you to have family, friends, and others you designate involved in your care. You can use this form to list people who you want us to talk with about your medical care.

How can I give someone permission to verbally discuss about me?
Fill out the Permission to Verbally Discuss Protected Health Information form to let us know who we can talk to. Check the boxes to tell us what information we may discuss.

How is the information on the form used?
We use this form to make sure we have permission to discuss your health information with people who may be involved in your care.

What are some examples of when this might be useful?

- A spouse, partner, parent, or friend has questions and needs help caring for a post-surgical patient.
- A college student wants information shared with a parent
- A spouse, partner, parent, or friend calls to find out a patient's appointment time
- A spouse, partner, or parent calls to inquire about a payment

Can the person I list on this form get copies of my medical records?
No, this form only gives Dr. J. J. Wendel Plastic Surgery permission to verbally discuss information. If you want us to share your medical records you must complete an Authorization to Release Protected Health Information. This form is on the Dr. J. J. Wendel Plastic Surgery website at https://www.drjjwendel.com/privacy-policy.

What if I change my mind?
You can cancel or change this permission form at any time by sending us a written statement.

What happens if I don't complete this form?
We will not discuss your protected health information except as allowed by law.

What are the rules for minor members?
A minor member can receive certain services without parental consent. In these instances the minor must sign this form to allow us to discuss their information.

Where do I send the completed form or any changes?
Dr. J. J. Wendel Plastic Surgery
2103 Crestmoor Rd
Nashville, TN 37215
Fax: (615) 921-2101
Email: greetings@drjjwendel.com

You may request these materials, free of charge, in other language or alternate formats by calling (615) 921-2100.

MEDICAL HISTORY

Patient's Name:	**DOB:**	**Today's Date:**
Current Concern (Reason you came to the doctor):		
Brief History of Present Condition:		

SOCIAL HISTORY

Smoking: ☐ No ☐ Yes Pack per Day _____ How Long _____ Quit Date _____	
Alcohol Use: ☐ None ☐ Rare ☐ Socially ☐ Frequent	**History of Alcohol Abuse:** ☐ Yes ☐ No
Recreational Drug Use: ☐ None ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Opioids ☐ Meth ☐ History of Drug Abuse ☐ Other_____	

SURGICAL HISTORY (Specify Type of Surgery with Dates)

Abdomen:	**Breast:**
Facial:	**Other:**
Anesthesia Problems: ☐ Yes ☐ No	**Please Explain:**

PAST MEDICAL HISTORY

None	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Other Cancer	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No
Breast Cancer	☐ Yes ☐ No	History DVT/PE	☐ Yes ☐ No	Skin Cancer	☐ Yes ☐ No
Bleeding Tendency	☐ Yes ☐ No	HIV/ AIDS	☐ Yes ☐ No	STD/I	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Eye Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
GI Disease	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Urinary Tract Infection	☐ Yes ☐ No
Heart Disease/MI	☐ Yes ☐ No	Mental Illness	☐ Yes ☐ No	Other:_____	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Neurologic Disease	☐ Yes ☐ No		

FAMILY HISTORY (Indicate which Blood Relative AND Maternal or Paternal)

Abnormal Bleeding	**Heart Disease**	**Stroke**
Adopted	**Malignant Hypothermia**	**Substance Abuse**
Breast Cancer	**Other Cancer**	**Other**
Diabetes	**Skin Cancer**	

CURRENT MEDICATIONS

☐ See List (Please list dosage and schedule) ☐ None	
1.	4.
2.	5.
3.	6.
Non-Prescription Drugs Aspirin: ☐ Yes ☐ No Ibuprofen: ☐ Yes ☐ No Homeopathic: ☐ Yes ☐ No SBE Prophylaxis: ☐ Yes ☐ No	
Steroids in the last 12 months: ☐ Yes ☐ No Do you take a Blood Thinner? ☐ No ☐ Yes Name:_____	

ALLERGIES TO MEDICATIONS/MEDICAL SUPPLIES ☐ No Known Drug Allergies

☐ Betadine ☐ Penicillin ☐ Lidocaine ☐ Latex ☐ Tape ☐ Other:_____

Have you had recent weight gain? ☐ Yes ☐ Recent weight loss ____ lbs loss ____ lbs gain

Height: _____ Current Weight: _____

REVIEW OF SYSTEMS

Allergies:	☐ Yes ☐ No	Facial Weakness:	☐ Yes ☐ No
Anxiety:	☐ Yes ☐ No	Fever / Chills:	☐ Yes ☐ No
Back/Neck Pain:	☐ Yes ☐ No	Frequent Sunburns:	☐ Yes ☐ No
Bleeding Tendency:	☐ Yes ☐ No	Nasal Obstruction:	☐ Yes ☐ No
Breast Mass/Lump:	☐ Yes ☐ No	Nerve Pain:	☐ Yes ☐ No
Breathing Problems:	☐ Yes ☐ No	Night Sweats:	☐ Yes ☐ No
Chest Pain or Tightness:	☐ Yes ☐ No	Paralysis:	☐ Yes ☐ No
Cold Sores :	☐ Yes ☐ No	Reflux:	☐ Yes ☐ No
Depression:	☐ Yes ☐ No	Scarring/ Keloids:	☐ Yes ☐ No
Difficulty Swallowing:	☐ Yes ☐ No	Shortness of Breath:	☐ Yes ☐ No
Difficulty Urinating:	☐ Yes ☐ No	Sinus Problems:	☐ Yes ☐ No
Double Vision:	☐ Yes ☐ No	Speech Changes:	☐ Yes ☐ No
Dry Eye:	☐ Yes ☐ No	Stomach Ulcer:	☐ Yes ☐ No
Enlarged Gland/Node:	☐ Yes ☐ No	Vision Loss:	☐ Yes ☐ No

FEMALE PATIENTS

Are you currently pregnant? ☐ Yes ☐ No

Do you take birth control pills? ☐ Yes ☐ No

Are you Planning Pregnancy? ☐ Yes ☐ No

Are you currently breastfeeding or lactating? ☐ Yes ☐ No

Have you had a mammogram? ☐ Yes ☐ No
If so, when?_____

Have you had a c-section? ☐ Yes ☐ No
If so, when?_____

TREATMENT AUTHORIZATION

To include but not limited to the administration and performance of all treatments; the administration of any needed anesthetics; the use of prescribed medication; the performance of procedures as may be deemed necessary or advisable in the treatment of this patient; the taking and utilization of cultures and of other medically accepted tests, all of which in the judgement of the attending physician are considered medically necessary.

Signature of Patient / Guardian: _____ **Date:** _____