Oasis
PLASTIC SURGERY™

Jennifer A. Geoghegan, M.D.

NEW PATIENT INFORMATION

Date: _____/_____/_____

Patient Name (Last) _____ (First) _____ (M) _____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone _____

Date of Birth_____/_____/_____ Age_____ Sex: M/ F Marital Status_____

Occupation_____ Retired: Y / N Employer_____

How did you hear about us? _____

Email Address_____
May we use your e-mail for medical related correspondence? N / Y
May we use your e-mail to invite you to Oasis Plastic Surgery promotions or events? N / Y

Preferred Contact Method (Circle one) Home Phone Cell Phone Email Mail

Emergency Contact _____ Relationship_____ Phone_____

Reason for Consultation_____

Are there any other topics which interest you? (Please check)

Breasts	☐	Brow	☐	Eyes	☐	Skin Care / Rejuvenation	☐
Face	☐	Lipo	☐	Ears	☐	Facial Fillers	☐
Tummy	☐	Botox	☐	Neck	☐	Hair Removal	☐

IF WE ARE BILLING YOUR INSURANCE COMPANY PLEASE COMPLETE THE FOLLOWING:

Primary Insurance Company_____ Patient Social Security #:_____
I.D.#_____ Policy or Group#_____
Policy Holder's Name _____ Relationship: _____
Holder's Employer _____ DOB ____/____/_____ Holder's Social Security# _____

Secondary Insurance Company_____
I.D.#_____ Policy or Group#_____
Policy Holder's Name _____ Relationship:_____ __
Holder's Employer _____ DOB ____/____/_____ Holder's Social Security# _____

STATEMENT OF FINANCIAL RESPONSIBILITY I understand that payment for services, whether cosmetic or not, is solely the responsibility of the patient or their guarantor and as a courtesy Dr. Geoghegan will bill my insurance. I hereby authorize Dr. Jennifer Geoghegan to bill my insurance company or other third parties responsible for my medical charges. I also authorize Dr. Geoghegan to release any medical information that may be requested by my insurance company to help with the process of my claims. I authorize and request that payment be made directly to Dr. Jennifer A. Geoghegan for all medical and surgical services. I understand that I am responsible for any balance not covered by my insurance company.

_____ _____/_____/_____
Signature of Patient/Responsible Party/Legal Guardian Date

Oasis
PLASTIC SURGERY™

Jennifer A. Geoghegan, M.D.

PATIENT HISTORY

Name_____ Date_____

Age_____ Height_____ Weight_____ Marital Status: Single Married Divorced Widowed

Allergies List any reactions you have had to medications and describe the symptoms.
_____

Medications List ALL prescription, over the counter, and herbal medications you are taking or have taken recently with dosages. _____
_____

Past Medical History List ANY medical condition for which you have been treated.
_____

Past Surgical History List ALL previous surgeries. Include any complications or abnormal reaction to anesthesia. _____
_____

Social History Occupation: _____

Exercise Habits: _____

Cigarette Smoking: Yes No ____ packs per day ____ number of years ____date quit

Alcohol Use: None Occasional Moderate Excessive

Drug Use: _____

MD Initial_____

Family History (Circle any that effect your siblings, parents or grandparents)

Anesthetic problems High blood pressure Heart disease Breast cancer Diabetes

Bleeding disorder Mental illness Other _____

Review of Systems (Please circle any of the following conditions that apply to you)

General: weight changes fatigue fever chills

Eyes: eye pain excessive tearing visual changes double vision eye irritation dry eyes red eyes glaucoma contact lenses sensitivity to light

Ears: ear pain ringing in the ears dizziness hearing loss

Nose: past nasal trauma past nasal surgery difficulty breathing through nose sinus problems

Mouth: dental problems tooth pain difficulty swallowing oral cancer dentures capped teeth

Cardiovascular: high blood pressure heart attacks heart surgery irregular heartbeat murmur chest pain congestive heart failure foot swelling rheumatic fever pacemaker

Respiratory: asthma shortness of breath bronchitis pneumonia recent cough TB

Gastrointestinal: peptic ulcers reflux indigestion vomiting diarrhea constipation Jaundice blood in stools black stools change in bowel habits hepatitis liver cirrhosis

Genitourinary: urinary tract infections yeast infections difficulty urinating frequent urination STD

Musculoskeletal: injuries swelling extremity pain joint pain arthritis leg cramps difficulty walking

Neurologic: seizures stroke dizziness sensory loss weakness

Psychiatric: depression alcoholism drug abuse anxiety marital problems

Hematologic: bleeding disorders anemia easy bruising bleeding gums swollen lymph nodes

Immunologic: HIV blood transfusions

Endocrine: diabetes thyroid disorder hypoglycemia adrenal disorders

Skin Disease: rashes new or changing lesions skin cancer

Allergies: food allergies latex allergies steroid use environmental allergies

Women's Health: Pregnancies _____ Live births _____ Miscarriages/Abortions _____
Last menstrual period _____ Are you pregnant? _____
Last mammogram _____ Results _____

Drug Use: diet aides aspirin herbal remedies blood thinners steroids chemotherapy accutane

MD Initial_____

Oasis
PLASTIC SURGERY™

Dr. Jennifer A. Geoghegan

PATIENT PHOTOGRAPHY RELEASE FORM

For your consideration, I, the undersigned, hereby give Oasis Plastic Surgery/Dr. Jennifer A. Geoghegan permission for use of my photographs as initialed:

_____ I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

_____ I hereby elect to grant permission to the use of my photographs for illustrating a medical procedure and demonstration of treatment outcomes in the office of Dr. Jennifer Geoghegan. It is also understood that the use of these photographs will in no way reveal patient identity.

_____ I hereby elect to grant permission to use and publish the same in whole or in part, individually or in conjunction with other photographs, in any medium for any purpose including art, illustration, promotion, website, internet, advertising, or trade.

I hereby release Oasis Plastic Surgery/Dr. Jennifer A. Geoghegan and its agents from any and all claims and demands arising out of, or in conjunctions with, the use of the photographs.

I am of legal age. I have read the foregoing fully and understand its contents.

Patient:

Print Name:_____

Signature: _____
(Legally Authorized Representative, if patient is under legal age)

Date: _____/_____/_____

Witness: _____

Oasis
PLASTIC SURGERY™

Jennifer A. Geoghegan, M.D.

NOTICE OF PRIVACY POLICIES

The Notice describes the health information about you that may be listed and disclosed and how you can get access to your health information. This is a required Privacy Regulation resulting from the Health Insurance Portability & Privacy Act of 1996 (HIPPA).

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information and to provide a copy of this information to you.

We may use and disclose your health information in the following ways:

1. **Physicians and staff may use or disclose your health information in order to treat you or to assist others in your treatment. We may also disclose your health information to others who may assist you in your care, such as, spouse, parents or children.**
2. **Our practice may use your health information to bill and collect payments, including your insurer or any third parties that may be responsible for such costs. We may also use your health information to bill you directly for services and items.**
3. **Our practice will use and disclose your health information if we are required to by law.**
4. **We may call you for appointment reminder purposes. Please advise us if you do not want us to call and leave appointment reminder messages at your home, answering machine or with co-workers at your place of work. We will make all efforts to keep this information confidential.**

Your rights concerning your health information:

1. **You can request that our practice communicate with you about your health and related issues in a particular manner. We will do our best to accommodate all reasonable requests.**
2. **You can request that we restrict our use of your health information for treatment, payment or health care operations, as well as, the release of this information only to certain individuals. We are not, however, required to agree to your request in some circumstances.**
3. **You have the right to inspect and obtain a copy of your medical and billing records. Your must submit your request in writing to your physician. You may ask us to amend your health information if you believe it is incorrect or incomplete. To request an amendment, you must supply us with a reason to support your request.**
4. **If you believe your privacy rights have been violated you may file a complaint with our office or with the Secretary of the Department of Health & Human Services. To file a complaint with our practice or if you have any questions about this policy notice, please contact your physician's Privacy Officer or Secretary at 480.264.6428.**

We have supplied you with our Notice of Privacy Practices. You will be asked to place your signature in your chart indicating that you have read, understood and agreed to this policy. A copy of this policy may be obtained from the receptionist at the front desk.

HIPPA Notice of Privacy Policies – Patient awareness verified:

Patient_____ Date _____
(or) Parent/Guardian _____

Oasis Plastic Surgery, PLLC.
9590 E. Ironwood Square Dr. #108
Scottsdale AZ 85258
P 480.264.6428 F 480.264.6429