



Ann K. Passmore, MD, FACS
Certified, American Board of Plastic Surgery



Member
AMERICAN SOCIETY OF
PLASTIC SURGEONS

Dear Patient,

We want to provide you with the highest quality care and excellent service. Please help us by taking a few moments to read the enclosed patient information and complete the forms. This information will acquaint you with our practice and procedures and make sure that your waiting time in our office is as brief as possible. We know your time is valuable.

Please bring the completed forms with you to your appointment. It is important that you give us as many details about your insurance as possible, including address and group and policy numbers. Copies of your insurance identification cards will be filed in your chart. This information enables us to provide the efficient service you deserve. If you have secondary insurance coverage, we will be happy to file a claim for you provided you have given us the necessary information.

If you are consulting us following an accident, we will need the date of the accident, the responsible party information including insurance information, and a telephone number to verify the insurance coverage.

We appreciate your assistance in completing these forms. Please call our office at (479) 274-6600 or 1-800-333-1305 with any questions you may have.

Thank you for your cooperation. We look forward to serving you at your scheduled time.

Sincerely,

Ann K. Passmore, M.D., F.A.C.S.
Certified, American Board of Plastic Surgery



3017 South 70th Street
Fort Smith, AR 72903
(479) 274-6600
1-800-333-1305
FAX (479) 484-4752



TODAY'S MONTH DAY YEAR / /



(479) 274-6600
(800) 333-1305

ANN K. PASSMORE, M.D., F.A.C.S.

3017 South 70th Street, Fort Smith, Arkansas 72903

PATIENT INFORMATION SLIP

OFFICE USE ONLY ACCEPTED BY
ACCOUNT NUMBER

PLEASE

This data sheet must be completed fully and accurately.

PATIENT NAME					
LAST	FIRST	MIDDLE INIT.	EMAIL ADDRESS		
		MONTH DAY YEAR	SEX M F		
SOCIAL SECURITY NUMBER		DATE OF BIRTH	AGE		
ADDRESS	STREET	APT. #	CITY	STATE	ZIP
() -	() -	S M W D Sep			
HOME PHONE	CELLULAR #	MARITAL STATUS - PLEASE CIRCLE		REFERRED BY	
				() -	
EMPLOYED BY	EMPLOYER'S ADDRESS	OCCUPATION		BUSINESS PHONE	
				() -	
NEAREST FRIEND OR RELATIVE NOT RESIDING WITH YOU			RELATIONSHIP TO YOU	PHONE	

PLEASE COMPLETE THE SECTION BELOW IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR THE BILL.

NAME:					
ADDRESS		CITY	STATE	ZIP CODE	
() -					
HOME PHONE	RELATIONSHIP TO PATIENT		SOCIAL SECURITY #		
				() -	
EMPLOYER	EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE	BUS. PHONE

INSURANCE INFORMATION

PLEASE PROVIDE ALL INFORMATION REQUESTED

#1 PRIMARY INSURANCE COMPANY	INSURANCE COMPANY NAME		INSURANCE COMPANY ADDRESS, CITY, STATE, AND ZIP CODE		
	GROUP	CONTRACT POLICY NUMBER	SUBSCRIBER'S NAME AND S.S. # AND DATE OF BIRTH		
	EMPLOYER	PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		PHONE NUMBER () -	
#2 SECONDARY INSURANCE COMPANY	INSURANCE COMPANY NAME		INSURANCE COMPANY ADDRESS, CITY, STATE, AND ZIP CODE		
	GROUP	CONTRACT POLICY NUMBER	SUBSCRIBER'S NAME AND S.S. # AND DATE OF BIRTH		
	EMPLOYER	PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		PHONE NUMBER () -	

IF YOUR CONDITION IS THE RESULT OF AN ACCIDENT, PLEASE INDICATE BELOW

WORK RELATED AUTO ACCIDENT OTHER (PLEASE SPECIFY) DATE OF ACCIDENT:

RESPONSIBLE PARTY

WORKER'S COMP. CARRIER OR CAR INSURANCE COMPANY			
COMPANY NAME			
ADDRESS			
STREET	CITY	STATE	ZIP
CONTACT NAME AND PHONE NUMBER			
ATTORNEY	NAME OF ATTORNEY, IF INVOLVED	STREET ADDRESS, CITY, STATE, ZIP	PHONE NUMBER () -



Cosmetic & Reconstructive Surgery

History Intake Form

Date: _____

Please answer each question as accurately as possible. If the question is unclear, please ask for assistance.

Patient Name _____ Birth Date _____
 Reason for visit _____ When did the problems start? _____
 _____ Is anything else occurring at the same time? _____
 Primary Care Doctor _____ If referred, who sent you? _____

Social History:

Do you drink over 6 cups of coffee daily? _____ Alcohol (type and amount per week) _____
 Smoking (type and amount per week) _____ If previous smoker, date quit _____
 Weight _____ Height _____ Drug Allergies _____
 List previous surgeries or major illnesses and dates: _____

Do you take Aspirin regularly? _____

Bring all current medications and vitamins or a detailed list with you to your appointment.

Family History:

Has any blood relative ever had the following:

Breast Cancer	NO	YES	High Blood Pressure	NO	YES	Kidney Disease	NO	YES
Melanoma	NO	YES	Heart Disease	NO	YES	Depression	NO	YES
Stroke	NO	YES	Diabetes	NO	YES	Arthritis	NO	YES

Past Medical History:

Have you ever had the following:

Heart Disease	NO	YES	Cancer	NO	YES	Stomach Ulcer	NO	YES
Arthritis	NO	YES	Glaucoma	NO	YES	Kidney Disease	NO	YES
Rheumatic Fever	NO	YES	Asthma	NO	YES	Thyroid Disease	NO	YES
Anemia	NO	YES	AIDS or HIV+	NO	YES	Bleeding Tendency	NO	YES
Tuberculosis	NO	YES	Stroke	NO	YES	Mitral Valve Prolapse	NO	YES
Diabetes	NO	YES	Hepatitis	NO	YES	High Blood Pressure	NO	YES
Epilepsy	NO	YES	Leukemia	NO	YES	MRSA	NO	YES

Review of Systems:

Do you have now or have you had within the past year:

Weight Change	NO	YES	Swollen Feet/Ankles	NO	YES	Seizures	NO	YES
Dry Eyes	NO	YES	Skin Rash	NO	YES	Joint or Muscle Pain	NO	YES
Chronic Cough	NO	YES	Chronic Diarrhea	NO	YES	Swollen Lymph Nodes	NO	YES
Chest Pain	NO	YES	Jaundice	NO	YES	Easy Bleeding	NO	YES
Rapid Heart Beat	No	YES	Depression	NO	YES	Easy Bruising	NO	YES

Women Only:

Age period began _____ Number of pregnancies _____
 Date of last mammogram _____ Did you breast feed? NO YES
 Do you do regular breast self-examination? NO YES Breast lump or discharge NO YES

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature of patient or parent of minor _____ Date _____
 NO CHANGE SINCE _____
 (OFFICE USE ONLY) _____

This Section Is To Be Completed by Patient

COOPER CLINIC, P.A.

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have received a copy of Cooper Clinic's

Patient Name

Notice of Privacy Practices.

Signature of Patient

____/____/____
DOB

Date

This Section Is To Be Completed by Cooper Clinic

COOPER CLINIC, P.A.

Documentation of "Good Faith" Efforts
To Obtain Written Information

Patient Name: _____

A written acknowledgement was not obtained from this patient because

___ Patient refused to sign

___ Other - Briefly Explain: _____

Signature of Employee Completing Form

Date



Ann K. Passmore, MD, FACS
 3017 South 70th Street, Fort Smith, AR 72903
 479.274.6600 • 800.333.1305
 www.passmoreplasticsurgery.com

COSMETIC SURGERY WAIVER

Patient Name: _____

From: Ann K. Passmore, M.D., F.A.C.S.

Insurance carriers will only pay for services that it determines to be “reasonable and necessary” for functional repair. I understand that my insurance carrier(s):

may determine that a particular service that I have chosen to have performed is “unnecessary” and for cosmetic purposes only. Ann K. Passmore, M.D., feels that in your case, your insurance carrier will deny payment for the following:

1. _____
2. _____
3. _____
4. _____

for the following reason: INSURANCE WILL CONSIDER THIS PROCEUDRE COSMETIC IN NATURE.

I have been notified by my physician that she believes that, in my case, the insurance carriers listed will deny payment for the services identified above for the reasons stated. I AGREE NOT TO FILE THIS CLAIM WITH MY INSURANCE CARRIER FOR PROCESSING AND AGREE THAT I AM PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT OF MY CHARGES.

 Patient Signature

 Date

 Witness