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.

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

COOPER CLINIC, PA

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

PATIENT INFORMATION SLIP

TODAY'S MONTH DAY YEAR / /

Plastic Surgery

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

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

3017 South 70th Street, Fort Smith, Arkansas 72903

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

SOCIAL SECURITY NUMBER | DATE OF BIRTH (MONTH / DAY / YEAR) | AGE | SEX (M F)

ADDRESS | STREET | APT. # | CITY | STATE | ZIP

( ) - HOME PHONE | ( ) - CELLULAR # | MARITAL STATUS - PLEASE CIRCLE: S M W D Sep | 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 ☐1 SELF ☐2 SPOUSE ☐3 CHILD ☐4 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 ☐1 SELF ☐2 SPOUSE ☐3 CHILD ☐4 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 ( ) -

COOPER CLINIC, P.A.
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

F4345A

COOPER CLINIC, PA

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