John M. Trupiano, MD, FACS
Plastic & Reconstructive Surgery

201 West Big Beaver Road, Suite 1130
Troy, MI 48084

Phone: (248) 220-3310
Fax: (248) 220-3311

Patient Intake Form

Date: _____

Last Name: _____ **First Name:** _____ **M.I.:** _____

Street Address: _____ **Apt./Suite:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell/Mobile Phone:** _____

Date of Birth: _____ **Age:** _____ **SS#:** _____

Email Address: _____

Employer: _____ **Occupation:** _____

Street Address: _____ **Apt./Suite:** _____

City: _____ **State:** _____ **Zip:** _____

Work Phone: _____

Emergency Contact Name: _____ **Phone Number:** _____

Street Address: _____ **Relationship:** _____

City: _____ **State:** _____ **Zip:** _____

Did a physician refer you to Dr. Trupiano? ☐ Yes ☐ No

Name: _____ **Specialty:** _____ **Phone:** _____

Street Address: _____ **Apt./Suite:** _____

City: _____ **State:** _____ **Zip:** _____

If you were not referred by a physician, how did you hear about Dr. Trupiano?

☐ Friend/Family: _____ **☐ DrTrupiano.com**

☐ Printed advertisement **☐ Dr Michael Schenden**

☐ Internet search

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I hereby warrant that I am over twenty-one years of age, and competent to contract in my own name insofar as the above is concerned.

I have read and understand the foregoing release, authorization and agreement, before signing my name below, and enter into it knowingly and voluntarily.

Date:_____ Printed Name:_____

Signature:_____

I have read the above Release and Authorization. I am the parent, guardian, or conservatory of _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization in the interest of public education.

Date_____ Printed Name: _____

Signature: _____

_____ **Patient Initials**

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Patient Insurance Awareness

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient, to check with your insurance company prior to any office or hospital procedures. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred during your office visit. Please remember – *your insurance policy is between you and your insurance company and not between the insurance company and your doctor*. Also, please be advised that lab work performed in the office is a completely separate charge from the physician's charges.

Dr. Trupiano has no control over your insurance plan regarding co-pays, deductibles, and coinsurance. It is your responsibility to be familiar with your insurance plan(s) prior to proceeding with your consult and/or procedure*. It is for this reason, co-pays, deductibles, and coinsurance will be collected prior to being seen by Dr. Trupiano and/or before any surgical procedure that is performed*.

Your signature below verifies that you have read and understand this statement and all your questions have been answered.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Print Name of Patient or Legal Guardian

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Patient Insurance Information

Primary Insurance:

Group #: _____

Contract #: _____

Name of Subscriber:

_____

Subscriber's Date of Birth: _____

Subscriber's Employer:

_____

Patient's Relationship to Subscriber:

_____

Secondary Insurance:

_____

Group #: _____

Contract #: _____

Name of Subscriber:

_____

Subscriber's Date of Birth: _____

Subscriber's Employer:

_____

Patient's Relationship to Subscriber:

_____

I give my authorization to release medical records to assist in the processing of my insurance claims. I also authorize payment of my claims to be mailed directly to the facility providing my services. I understand that I am completely responsible for any charges incurred and the billing of my insurance does not guarantee payment of the claim(s). Patient balances are due 30 days after an insurance coverage payment has been made. *John M. Trupiano M.D., P.C. reserves the right to assess a service charge of $20 per month for any unpaid balance over 30 days after the insurance coverage has been paid.* No service charges will be assessed to a patient account where the patient has made payment arrangements with the Office Manager at John M. Trupiano, M.D., P.C. and payments are being made as agreed. Returned check fee applied is $30.00. If this account is assigned to a collection agency or a lawsuit, the prevailing party may be entitled to reasonable attorney fees, $50.00 cost of collection fee, and/or collection agency fee. *Ninety (90) days after the date of service, any unpaid amounts will be processed for collection services or a lawsuit and finance charges applied.* I agree to the terms of service and I authorize any treatment deemed necessary by John M. Trupiano, M.D.

_____ _____

Patient or Legal Guardian Signature **Date**

Note to patients under the age of 18: You must have the consent of a parent or legal guardian before you can be seen and treated in this office.

This is to confirm that I give my permission to have _____, a minor, examined and treated. It is requested that this includes a complete exam, and treatment.

_____ _____

Patient or Legal Guardian Signature **Date**

Please present your insurance card(s) and driver's license with this form. Thank you.

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HIPAA Consent for Purposes of Treatment, Payment, and Healthcare Operations

With my consent, John M. Trupiano, M.D., P.C. may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). Please refer to John M. Trupiano, M.D., P.C.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

My Protected Health Information means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, or a healthcare clearinghouse. This Protected Health Information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. And, that John M. Trupiano, M.D., P.C. reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to John M. Trupiano, M.D., P.C., Attn: Privacy Officer, at 201 West Big Beaver road, Suite 1130, Troy, MI 48084.

With my consent, John M. Trupiano, M.D., P.C. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and prescriptions among others.

With my consent, John M. Trupiano, M.D., P.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, John M. Trupiano, M.D., P.C. may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that John M. Trupiano, M.D., P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to John M. Trupiano, M.D., P.C. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, John M. Trupiano, M.D., P.C. may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian

Patient Name: _____

Date: _____

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Medical History: Check the conditions which apply to you. Write the approximate year of occurrence or onset next to each checked condition.

✓	YEAR	CONDITION	✓	YEAR	CONDITION	✓	YEAR	CONDITION
		Anemia			Deep Vein Thrombosis (DVT)			High Blood Pressure
		Anesthetic Reaction			Diabetes (Insulin: Y/N)			High Cholesterol
		Angina/Chest Pain			Drug Dependency			Hypoglycemia
		Arthritis			Emphysema			Hypothyroidism
		Asthma			GERD/Acid Reflux			Irregular Heart Beat
		Bladder Infection			Glaucoma			Kidney Problems
		Bleeding Problem			Headaches/Migraines			Paralysis
		Blood Transfusion			Hearing Problems			Seizures/Convulsions
		Breathing Problem			Heart Attack			Skin Disorders
		Bronchitis			Heart Failure			Stroke
		Cancer (type:)			Heart Murmur			Ulcers
		Circulation Problem			Hepatitis/Jaundice			Tuberculosis
		Cirrhosis			Hiatal Hernia			Other:

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

YEAR	OPERATION/ MEDICAL PROBLEM	YEAR	OPERATION/ MEDICAL PROBLEM

Medications: List all medications (prescription and non-prescription) you are presently taking. Include frequency and dose.

MEDICATION	FREQUENCY	DOSE	MEDICATION	FREQUENCY	DOSE

Allergies: List all known drug allergies and reaction.

ALLERGIC TO:	REACTION	ALLERGIC TO:	REACTION

Patient Name: _____

Date: _____

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Social History:

Marital Status:	☐Single	☐Married	☐Separated	☐Divorced	☐Widowed
Tobacco Use:	☐Never	☐Quit _____ years ago		☐Current packs per day___x___years	
Alcohol Use:	☐Never	☐Rarely	☐Moderate	☐Daily	
Street Drug Use:	☐Never	☐Type/Frequency_____			

SYSTEM REVIEW: Please check Yes or No for each item.

Height: _____ **Weight:** _____

General Symptoms

Good general health lately	☐Yes	☐No
Fatigue	☐Yes	☐No

Eyes

Glaucoma	☐Yes	☐No
Cataracts	☐Yes	☐No
Visual changes	☐Yes	☐No

Ears/Nose/Mouth/Throat

Chronic sinus problems	☐Yes	☐No
Sore throat	☐Yes	☐No
Swollen glands in neck	☐Yes	☐No

Cardiovascular

High blood pressure	☐Yes	☐No
Chest pain/angina	☐Yes	☐No
Pacemaker	☐Yes	☐No

Respiratory

Chronic or frequent cough	☐Yes	☐No
Shortness of breath	☐Yes	☐No
Sleep apnea	☐Yes	☐No
Asthma	☐Yes	☐No
Emphysema	☐Yes	☐No
Tuberculosis	☐Yes	☐No

Breasts

Pain in breasts	☐Yes	☐No
Discharge from nipple(s)	☐Yes	☐No
Breast mass/lump	☐Yes	☐No
Previous breast surgery	☐Yes	☐No
Regular mammograms	☐Yes	☐No
Date of last mammogram: _____		

Gastrointestinal

Poor appetite	☐Yes	☐No
Nausea or vomiting	☐Yes	☐No
Frequent diarrhea	☐Yes	☐No
Constipation	☐Yes	☐No
Blood in stool	☐Yes	☐No

Genitourinary

Frequent urination	☐Yes	☐No
Blood in urine	☐Yes	☐No
Incontinence/dribbling	☐Yes	☐No
Kidney failure/dialysis	☐Yes	☐No
Kidney transplant	☐Yes	☐No
Discharge from penis/vagina	☐Yes	☐No

Integument (Skin)

Bleeding or bruising tendency	☐Yes	☐No
Change in mole	☐Yes	☐No

Musculoskeletal

Joint pain	☐Yes	☐No
Joint stiffness	☐Yes	☐No
Weakness of muscles or joints	☐Yes	☐No
Back pain	☐Yes	☐No
Osteoarthritis	☐Yes	☐No

Neurological

Frequent/recurring headaches	☐Yes	☐No
Light headed or dizzy	☐Yes	☐No
Fainting or unconscious spells	☐Yes	☐No

Endocrine/Hepatic

Excessive thirst/urination	☐Yes	☐No
Diabetes	☐Yes	☐No
Heat/cold intolerance	☐Yes	☐No
Thyroid disease	☐Yes	☐No
Hepatitis	☐Yes	☐No

Hematologic/Lymphatic

Anemia	☐Yes	☐No
Human Immunodeficiency Virus	☐Yes	☐No

Psychiatric

Depression	☐Yes	☐No
Claustrophobia	☐Yes	☐No