Patient Registration

John L. Burns, M.D.
9101 N. Central Expressway
Suite 600
Dallas, TX 75231

Referred By	Account No. (Office Use Only)
	Date

How did you hear about us?

Would you like to be added to our mailing list? ☐ Yes ☐ No Thanks

Patient

Full Name			
Social Security No.	D.O.B.	Age	☐ Male ☐ Female
Home Phone	Work Phone	Fax Phone	
Cell Phone	Preferred Phone	Pharmacy Phone	
Email Address		Drivers License No.	
Mailing Address			
City, State, Zip			

Employment (if minor, responsible parties)

Employed By	
Position	May we call you at work? ☐ Yes ☐ No
Address	

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name	Social Security No.
Spouse's Employer	Phone No.
Address	

In Case of Emergency

Name	Relationship	Phone No.
Name	Relationship	Phone No.

I understand that I am financially responsible for all charges. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, money orders and most major credit cards.

Signature _____ Date _____

Health History Form

Dr. _____

Name					Date
Address					
D.O.B.	Age	Height	Weight	Home Phone	Work Phone
Reason for visit today?					

Past/Current Hx (Check all applicable)

☐ Lung Disease	☐ High Blood Pressure	☐ Asthma	☐ Keloids	☐ Abnormal or Excessive Bleeding
☐ Liver Disease	☐ Mitral Valve Prolapse	☐ Hepatitis	☐ MRSA	☐ Taken Accutane with in Past Year
☐ Kidney Disease	☐ Chest Pain	☐ HIV	☐ Fever Blisters	☐ Neck Problems
☐ Heart Disease	☐ Diabetes	☐ Seizures	☐ Dry Eyes	☐ Sleep Apnea
				☐ Use CPAP/BPAP

Other Major Illnesses:

Medications: Name	Reason for Taking	Frequency/Dose

Do you take ANY Diet Pills, Natural Herbs or Health Food Supplements? If Yes, What: _____

_____

_____

Allergies and Reactions to Medication? _____

_____

Previous Surgeries: _____

_____

_____

Have you or anyone in your family had complications from anesthesia? If Yes, please explain: _____

_____

_____

Has anyone in your family had breast cancer before the age of 50? If Yes, please explain: _____

_____

Have you been on ANY steroids in the last year? If Yes, please explain: _____

_____

Do you take asprin on a regular basis? ☐ Yes ☐ No

Do you have excessive bleeding or bruising? ☐ Yes ☐ No

Do you use any Tobacco products? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Do you have any teeth that are: ☐ Loose ☐ Fragile ☐ Capped ☐ False

Signature	Date

JOHN L. BURNS M.D.
9101 N. CENTRAL EXPRESSWAY #600
DALLAS, TEXAS 75231

PHOTOGRAPH CONSENT FORM

I, the undersigned, hereby authorize John L. Burns M.D. to take my pre-photos and post-photos for planning purposes, medical evaluation, surgical or other procedures and subsequent treatment. I understand that such photos are an important part of my medical treatment and confidential medical file, and medical services will be refused if such photos are refused by the patient. Additionally, your photos will not be used in any publication or on the internet without your consent, as provided below. I understand my name will not be revealed with the photos or in the descriptive text accompanying any such photographs. I herein relinquish any right, title or interest in such photographs.

PERSON PHOTOGRAPHED:

_____ (Check Mark) I consent for my photos to be used by John L. Burns M.D. in publications or on the internet, with the understanding that my name will not be revealed with the photos or in the descriptive text accompanying the photographs.

PATIENT SIGNATURE: _____

DATE: _____

WITNESS SIGNATURE: _____

DATE: _____

DALLAS PLASTIC SURGERY INSTITUTE

Patient Consent and Acknowledgment of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Dallas Plastic Surgery Institute creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must agree to any restriction on the use and disclosure of my Protected Health Information that I request in writing, when I request in writing, agree to terminate any restrictions on the use and disclosure of my protected Health Information which have been previously agreed upon.

(PATIENT'S NAME PRINTED)	DATE
PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)	SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)
WITNESS (optional)	DATE

DALLAS PLASTIC SURGERY INSTITUTE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting your privacy
Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At Dallas Plastic Surgery Institute (hereafter referred to as "the Practice"), privacy is one of our highest priorities.

Keeping your information
Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.
We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles

Working to meet your needs through information
In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide service to you, to process your claims and to bring you health information that might be of interest to you.

Keeping information accurate
Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please contact us. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How - and why - information is shared
We limit who receives information and what type of information is shared.

- *Sharing information within the Practice.* We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.

- *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.

- *Other.* Patient-specific personally identifiable date is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including goverment agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy
You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us-whether it's at our office, over the phone or through the Internet.