CENTRAL OHIO PLASTIC SURGERY, INC. (740) 653-5064

Patient Information as of _____ (enter today's date)

(Please Print Legibly & Correct or Fill In All Fields)

PATIENT INFO

_____ _____ _____ _____

First Name Middle Name Last Name Nickname

Address _____ _____ _____ _____

Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

May we send a **text message** and/or leave a **voicemail?** ☐ No ☐ Yes E-mail: _____

First Attempt to contact you should be (**circle one**): **Home Phone Cell Phone Email**

If patient is under 18: Parents' names: _____

If patient is under 18: Who may authorize treatment: _____

Age **Birthdate** _____ **SS#** _____ ☐ Female ☐ Male

Marital Status ☐ Single ☐ Married to: _____ Other: _____

EMERGENCY CONTACT Name: _____ Relationship to Patient: _____

HomePhone: _____ Work Phone: _____ Mobile Phone: _____

Address _____

PATIENT'S EMPLOYER_____ **If retired, effective date:** _____

Occupation: _____

Address_____

DEMOGRAPHIC INFORMATION

Race: ☐American Indian or Alaska Native ☐Black or African American ☐White ☐Asian ☐Prefer not to answer

Are you Hispanic/ Latino? ☐ No ☐ Yes ☐Prefer not to answer **Preferred Language:**☐English ☐Other_____

INSURANCE INFORMATION

Either as primary or secondary, do you have:

☐ Neither Medicare nor Medicaid ☐ Medicare ☐ Medicare Advantage or Replacement ☐ **Any** Medicaid plan

If you have Medicare/ Medicare Advantage **AND** Medicaid, are you a Qualified Medicare Beneficiary (QMB) ☐ Yes ☐ No

Primary Health Insurance Co_____ Policy#_____ Group#_____

Relationship to Insured: Self Child Spouse Partner Other

Insured Name:_____DOB (required):_____SSN:_____

Insured's Employer: _____

Secondary Health Insurance Co. _____ Policy # _____ Group # _____

Insured Name: _____ DOB (required)::_____ SSN:_____

I understand that office visit charges are payable on the day service is rendered. I authorize Central Ohio Plastic Surgery, Inc. and Dr. Lichten to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Central Ohio Plastic Surgery, Inc. and myself.

Signature _____ Date _____

HEALTH HISTORY – New Patient
Name: _

Central Ohio Plastic Surgery, Inc.
Date of Birth:

Why are you seeing Dr. Lichten today? _____

Height: ___ft ___ in

Weight: _____ lbs. Any Recent Change? (explain) _____

Medical History: (**Circle** yes or no for **each and explain**)			**Details:**
Heart Disease (Heart Attack, Surgery, CHF, MVP, Arrythmia)	Yes	No	
Have you seen a Cardiologist or had any cardiac testing since your last visit?	Yes	No	
Hypertension (High blood pressure) What Medications?	Yes	No	
Lung Disease (Asthma, COPD, Sleep Apnea, CPAP use)	Yes	No	
Diabetes – Include current medications	Yes	No	
Thyroid Problems (Hypothyroidism/Hyperthyroidism)	Yes	No	
Liver Problems (Hepatitis/Cirrhosis)	Yes	No	
GI Problems (Ulcer/IBD/Chron's/UC)	Yes	No	
Kidney/Renal Disease	Yes	No	
Bleeding Disorders (Including use of blood thinners)	Yes	No	
History of Blood Clot or Pulmonary Embolism	Yes	No	
Skin Cancer History (Melanoma/Basal Cell/Squamous Cell)	Yes	No	
Other Cancer History (Breast/Other)	Yes	No	
Family History of Breast Cancer (who?)	Yes	No	
Neurologic Disorders (Stroke/Seizures/TIA)	Yes	No	
Anxiety/Depression	Yes	No	
Arthritis/Musculoskeletal Disorders	Yes	No	
Use of Weight Loss Medications	Yes	No	
Antibiotics are recommended by my physician prior to any procedure? Who and why?	Yes	No	
Any previous problems with anesthesia?	Yes	No	
Do you currently smoke?	Yes	No	
Other Medical Conditions	Yes	No	

Previous Surgeries: (include surgeries as a child and an adult) _____

_____

Current Medications: (include prescription, over the counter, vitamin and herbal remedies) _____

_____

_____

ALLERGIES and Reactions to Medications/Latex/Glue: (please **indicate if none**) _____

_____

Allergies to any food, particularly nuts and eggs: _____

HEALTH HISTORY – New Patient
Name: _

Central Ohio Plastic Surgery, Inc.
Date of Birth:

Family History: (including problems with Anesthesia. Include relation and illness) _____

_____

_____

Social History

Do you consume any **alcoholic beverages**? □ Yes □ No **How many per week?** _____

Do you, or did you ever, **use nicotine products**? □ Yes □ No If so, **what kind? Cigarettes / Chew / Vape / Other**_____

If so, **how much per day?** _____ For **how many years?** _____

When did you, or are you trying to **quit**? _____

Do you use any **recreational drugs**? □ Yes □ No If so, **what**? _____

Cardiology History

Have you seen a **cardiologist**? □ Yes □ No If so, **who** and **why**? _____

When was your last appointment? _____

Have you ever had a **cardiac stress test**? □ Yes □ No If so, **where, when** and **results**? _____

Have you ever had a **cardiac cath**? □ Yes □ No If so, **where** and **when** and **results**? _____

Do you have a **pacemaker**? □ Yes □ No If so, when was your last interrogation? _____

Family Physician Information

Who is your **primary care physician?** _____

What is their **phone number?** _____

Pharmacy Information

What is your **preferred pharmacy name and location**? _____

What is their **phone number?** _____

Women Only

Are you **currently** or do you **plan** to become pregnant in the next 6 months? □ Yes □ No

Total number of **pregnancies**: _____

Total number of **live births**: _____

Did you **breastfeed**? □ Yes □ No

Have you had a **mammogram** within the last 2 years? □ Yes □ No **(Please list reason)** _____

If so, **where, when** and **what** were the **results**? _____

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____

Financial Policy
Effective 1/2/2025

Central Ohio Plastic Surgery, Inc. recognizes the importance of communicating our financial policy to all patients. This policy applies to both self-pay and insurance patients. Please contact us at (740) 653-5064 with any questions or to discuss any aspect of our financial policy.

On your initial visit, you will be asked to provide demographic information. Following that visit, periodic updates will be requested. If, during the time you are a patient at our practice, **you change any of your personal information,** including address or telephone number, you must inform us.

There will be a $25.00 charge for all **FMLA and Disability** paperwork completed by Dr. Lichten. Please allow seven business days for processing. There will be an additional fee to expedite the paperwork. In no event can completion of paperwork be guaranteed in less than three business days.

*As part of your care, you may incur **additional medical bills** such as:*

- *Laboratory, Radiology or Pathology testing fees*
- *Consulting Physician Fees*
- *Facility Fees and/ or Anesthesia Fees*
- *Hospital Admissions or Emergency Room visit(s) Fees.*

It is our policy not to reimburse patients for any expenses arising from, or related to, services provided or recommended by Dr. Lichten. Patients should check with their medical insurance carrier about coverage and benefits for specific services required.

All patients who have a **check returned for insufficient funds** will be charged a service fee of $45.00, in addition to the original amount of the check.

Insurance Patients are responsible for supplying us with correct and updated insurance information at each visit. Failure to do so may result in you being liable for the entire balance of your bill. As a courtesy, we will submit claims on your behalf to your medical insurance carrier. When you are treated at our facility, you are required to pay any co-pay at the time of service. If you do not have insurance that covers the cost of your visit, or if you are unable to provide sufficient insurance information, you will be expected to pay 100% of the charges at your visit.

Self-pay Surgery Deposit Policy
For self-pay patients scheduling surgeries, the following deposit fees will apply.

- **Surgeries under 3 hours:** A $500 deposit is required to secure the surgery date.
- **Surgeries 3 hours or longer:** A $1000 deposit is required to secure the surgery date.

This deposit will be applied toward the total surgeon's fees for the surgery.

Refund Policy

- If the consult fee was applied to the deposit, that amount is non-refundable upon completion of the consultation.
- The deposit is **refundable** only within **7 days** of the deposit date.
- **Cancellations or rescheduling** requests made **after 7 days** will result in the deposit being **non-refundable** and will be forfeited to the practice.

The non-refundability of the deposit is not meant to be a punishment. There is considerable time and effort that goes into the scheduling of and planning for a surgery. The deposit is meant to cover the expense of those efforts in the event of a cancellation.

My signature below indicates that I understand and agree to the above policy.

Signature _____ Date _____

A signed copy of this form is available to you upon request. Please see a member of our staff to receive a photocopy of this record.

CENTRAL OHIO PLASTIC SURGERY, INC.

ACKNOWLEDGMENT AND CONSENT
PRIVACY PRACTICES

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you.

Yes ( ) I would like to receive a copy of the Notice of Privacy Practices for Central Ohio Plastic Surgery, Inc. (Please ask receptionist for a copy)

No ( ) I do not wish to take a copy of the Notice of Privacy Practices at this time.

We take our patients' privacy very seriously in this office and we will not disclose any information without your consent.

Do you give permission for our office to discuss your health history or any medical concerns with anyone other than yourself?

( ) YES ( ) NO

If yes, please list the individual(s) and their relationship to you.

Name(s): _____ Relationship: _____

Name(s): _____ Relationship: _____

Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign
( ) Communications barriers prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining acknowledgement
( ) Other (Please specify)