



Seton Institute of Reconstructive Plastic Surgery

A member of the Seton Healthcare Family

Hand • Breast • Advanced Facial Surgery • Wound Care • Plastic Surgery

Dear New Patient:

We would like to take this opportunity to welcome you to our practice.

In this packet you will find the Seton Institute of Reconstructive Plastic Surgery new patient paperwork for you to fill out and bring with you to your first appointment. Our HIPPA Privacy Policy is also included; please read the policy and it is yours to keep for your records. We ask that you please arrive to the clinic for your appointment at least 30 minutes early to allow for processing of your paperwork so that we may be prepared to see you at your scheduled appointment time. Next, you will find driving directions to our Austin clinic which also includes instructions on how to get to our clinic from the Clinical Education Center and University Medical Center Brackenridge parking garages.

For the benefit of our patients we are contracted with several insurance carriers as a provider. As part of our contract with the insurance companies we are legally required by the terms of the contract to collect any co-pays or deductibles from you at the time of service. Prior to your appointment, our office will verify your insurance benefits, if any, and you will be notified during your pre-appointment reminder call of what your co-pay/co-insurance obligations will be for each visit. We do ask that you be prepared to pay your co-pay/ co-insurance payment at the time of check in. For your convenience we accept cash, check, MasterCard and Visa.

We look forward to seeing you at the clinic, and we will do our best to make your visit as pleasant and efficient as possible. If you have any questions regarding our clinic or specifically your visit to our clinic please feel free to contact us at (1-877-977-3866). Please visit our website at www.SetonPlasticSurgery.com for more detailed information on our practice and physicians. Thank you for giving us the opportunity to serve you and your family.

James Cullington, MD • Nabil Habash, MD • Raymond Harshbarger, MD • Steven Henry, MD
Patrick Kelley, MD • Sanjay Sharma, MD • Adam B. Weinfeld, MD



Seton Institute of Reconstructive Plastic Surgery

A member of the Seton Healthcare Family

Hand • Breast • Advanced Facial Surgery • Wound Care • Plastic Surgery

DRIVING & PARKING DIRECTIONS

FOR OUR AUSTIN LOCATION

The Seton Institute of Reconstructive Surgery is located at 1400 N. IH 35, Suite 320. The clinic can be found in the Clinical Education Center (CEC) which is a part of University Medical Center Brackenridge. If you have any issues finding the clinic please feel free to call our office at (512) 324-8320 and we will be happy to help direct you to the clinic.

From North Austin:

Head south on I-35. Take Exit 235A toward 15th St. Merge onto East Ave/I-35 Frontage Road. When you reach 15th Street you will see Brackenridge Hospital on your right. Proceed through the light at 15th Street and take your first right turn into the CEC driveway. At that time you will see the entrance for the CEC parking garage on your left.

From South Austin:

Head north on I-35. Take Exit 235A toward University of Texas/15th St. /Martin Luther King Blvd./State Capitol. Merge onto the I-35 Frontage Road. Take the U-turn that is available just before the 15th Street light to head back south on the IH 35 frontage road. When merging onto the IH 35 frontage road you will need to get in the far right lane. After the u-turn you take your first right turn into the CEC driveway. At that time you will see the entrance for the CEC parking garage on your left.

Entering through the Clinical Education Center:

Once in the Clinical Education Center lobby, take the elevator to the third floor. The Seton Institute of Reconstructive Plastic Surgery is located in Suite 320, down the hallway to the left.

Entering from University Medical Center Brackenridge:

From the UMC Brackenridge Lobby on the 2nd floor, pass the main elevators and follow the hallway around to the right. The hallway will wind around, but continue to follow, staying to the right when needed. You will eventually cross the skywalk and enter the CEC. Stay to the right (you will pass classrooms and offices). At the end of the hallway, turn to the right and enter the CEC elevator bank. Take the elevator to the 3rd floor. The Seton Institute of Reconstructive Plastic Surgery is located in Suite 320, down the hallway to the left.

James Cullington, MD • Nabil Habash, MD • Raymond Harshbarger, MD • Steven Henry, MD
Patrick Kelley, MD • Sanjay Sharma, MD • Adam B. Weinfeld, MD



Seton Institute of Reconstructive Plastic Surgery

A member of the Seton Family of Hospitals

1400 N. IH-35, Suite 320 Austin, Texas 78701

Phone: (512) 324-8320 • Toll-Free Phone: (877) 977-3866 • Fax: (512) 324-8323

Demos:

How were you referred to our practice? Friend _____ Dr. _____ Hospital _____ Clinic _____ Ins _____ Ad _____ Ph book _____ Other _____

Have you been seen in the ER? _____ Yes _____ No _____ If Yes, Where _____

PATIENT INFORMATION

Patient Name (Last, First, MI) _____ Sex (circle) Female Male

Address _____ Apt# _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Email address _____ **Please circle the number/email at which you prefer to be contacted.**

Date of birth _____ Social Security # _____ Drivers license# _____

Employer/School Name _____ Occupation _____

Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Primary Insurance Company _____ Policy# _____ Group# _____

InsuranceCo.Address _____ City _____ State _____ Zip _____

Insurance Co. Phone _____ **Primary Care Physician** _____ Phone _____

Policy Holder Name (Last, First, MI) _____ Relationship to patient _____

Policy Holder Address _____ City _____ State _____ Zip _____

Policy Holder Date of Birth _____ Policy Holder Social Security # _____

Policy Holder Employer _____

Employer Address _____ City _____ State _____ Zip _____

Secondary Insurance Company _____ Policy# _____ Group# _____

InsuranceCo.Address _____ City _____ State _____ Zip _____

Insurance Co. Phone _____ Policy Holder Name (Last, First, MI) _____

Relationship to patient _____ Policy Holder Date of Birth _____ Policy Holder Social Security # _____

Policy Holder Address _____ City _____ State _____ Zip _____

Policy Holder Employer _____

Employer Address _____ City _____ State _____ Zip _____

RELEASE OF INFORMATION With whom may we share your medical information:

EMERGENCY INFORMATION

Name of Person to Contact in an Emergency _____ Relation to patient _____

Phone _____ Alternate Phone _____

AUTHORIZATION

Consent for treatment: I authorize the physicians at Seton Institute of Reconstructive Plastic Surgery to provide me with reasonable and proper medical care according to today's standards.

Financial Responsibility, Authorization to Release Information, Assignment of Benefits: I authorize Seton Institute of Reconstructive Plastic Surgery to release information in connection with my treatment to my insurance company or companies, my employer or any third party payer at such time as information is requested. I authorize assignment of benefits to Seton Institute of Reconstructive Plastic Surgery.

I understand and agree that I am financially responsible for any and all charges incurred.

May we contact you at your email address? Yes _____ No _____

Patient or Guardian Signature _____ Date _____



**Seton Institute of
Reconstructive Plastic Surgery**

A member of the Seton Family of Hospitals

1400 N. IH-35, Suite 320 Austin, Texas 78701

Phone: (512) 324-8320 • Toll-Free Phone: (877) 977-3866 • Fax: (512) 324-8323

Report of Accident Details:

Name of Individual Injured:

Date of Accident:

Did this Accident Occur at Work: YES NO

Accident Location:

Body Part Injured:

Brief Description of Accident:

Patient or Guardian Signature:

Printed Name:

Date:



Seton Institute of Reconstructive Plastic Surgery

A member of the Seton Family of Hospitals

1400 N. IH-35, Suite 320 Austin, Texas 78701

Phone: (512) 324-8320 • Toll-Free Phone: (877) 977-3866 • Fax: (512) 324-8323

Authorization to Release Medical Photographs:

I, _____, hereby authorize the physician and/or his associates, to take pre-operative, intra-operative, and post-operative photographs, appropriate for my surgery. I further authorize the physician and his associates to use the photographs for professional medical purposes deemed appropriate, including, but not limited to chart documentation, testing and credentialing, educational purposes for other physicians and patients, and for medical presentations, teaching, and/or journal articles. I will also allow my photographs to be used for other practice marketing purposes such as brochures, newsletters, and/or physician's websites. The physician or his associates will notify me if my photos will be utilized in any of the above manners, and I agree to have the right to refuse their usage. I understand that I will not be entitled to any payment or other form of compensation as a result of any use of the photographs.

Patient or Guardian Signature: _____

Printed Name: _____

Date: _____



Seton Institute of Reconstructive Plastic Surgery

A member of the Seton Healthcare Family

Hand New Patient Information Form:

Primary Care Physician & Address: _____

Primary Care Physician Phone: _____ Fax: _____

Are you Right or Left handed?

Is this a work related problem? YES NO If yes, list your TWCC#: _____

Employer/Occupation: _____

If disabled, when did you last work? _____

Do you have a lawyer involved with this problem? YES NO If yes, whom? _____

Reason for visit: _____

Where is the problem located? Right, Left, or Both (please be specific): _____

Date of injury: _____

When and how did this problem begin? _____

Circle the symptoms that describe your problem:

stiffness pain instability numbness swelling

If you have pain, please circle the description that is most appropriate:

sharp throbbing dull aching burning stabbing heavy

Circle the number corresponding to the intensity of your pain or symptoms:
(1 is no pain and 10 is the worst pain imaginable)

1 2 3 4 5 6 7 8 9 10

Circle all that apply: Is your pain getting:

better better gradually better rapidly getting worse worse gradually worse rapidly

What improves your symptoms? _____

What makes your symptoms worse? _____

Please list any surgeries: None

Date	Surgery	Date	Surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have problems with anesthesia? Yes No If yes, explain _____

Name: _____ Date: _____



Seton Institute of Reconstructive Plastic Surgery

A member of the Seton Healthcare Family

Hand New Patient Information Form Continued:

Family History (Parents, Siblings, Children)

Bleeding Disorder	Yes	No	Problems with anesthesia	Yes	No	
Diabetes	Yes	No	Asthma		Yes	No
High Blood Pressure	Yes	No	Breast Cancer	Yes	No	
Heart Disease	Yes	No	Other Cancer		Yes	No
Arthritis	Yes	No	Stroke		Yes	No

Social History:

Marital Status: Single Married Divorced Widowed

Do you smoke or use any tobacco products? Yes No How much per day? _____

Do you consume alcohol? Yes No How many per week? _____

Current Medications: Please list all prescription and over the counter medicines you are taking: None

Medication	Dose	Medication	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medication Allergies: Yes No If yes, to what? _____

Other Allergies: Yes No If yes, to what? _____

Labs: Have you had any labs for this problem? _____

Studies: Have you had any radiographic studies for this problem? _____

Are there any special needs for this visit? Yes No If yes, please explain:

Are you interested in learning about cosmetic surgery? Yes No If yes, please explain:

Name: _____ Date: _____



Seton Institute of Reconstructive Plastic Surgery

A member of the Seton Healthcare Family

Hand New Patient Information Form Continued:

Review of Systems:

Do you have any of the following medical problems? Please circle and check boxes below

	YES	NO	Comments
General (weight gain, weight loss, fatigue, insomnia, fever)	<input type="checkbox"/>	<input type="checkbox"/>	
Vision (glasses, contact lenses, cataracts, glaucoma)	<input type="checkbox"/>	<input type="checkbox"/>	
Ear / Nose / Throat (sinus problems, hearing loss, ringing in ears)	<input type="checkbox"/>	<input type="checkbox"/>	
Heart (irregular heartbeat, murmur, high blood pressure, heart disease)	<input type="checkbox"/>	<input type="checkbox"/>	
Pulmonary (short of breath, lung disease, persistent cough, sleep apnea)	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach and Intestinal (decreased appetite, constipation, heartburn, nausea, vomiting, diarrhea, hepatitis A, B, C)	<input type="checkbox"/>	<input type="checkbox"/>	
Muscle and Skeletal (arthritis, fractures, sprains, spine problems)	<input type="checkbox"/>	<input type="checkbox"/>	
Genital Organs and Urinary System (kidney stones, bladder or kidney infections, kidney disease, prostate problems)	<input type="checkbox"/>	<input type="checkbox"/>	
Skin (swelling, blisters, dermatitis, eczema, acne, keloids)	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological (problems with swallowing, seizures, tingling sensation, numbness, severe headaches)	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric (anxiety, depression, bulimia, anorexia, other)	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine (increased thirst, diabetes, thyroid disease)	<input type="checkbox"/>	<input type="checkbox"/>	
Hematology (bleeding problems or clots, anemia)	<input type="checkbox"/>	<input type="checkbox"/>	
Immune (swollen or enlarged lymph nodes, cancer)	<input type="checkbox"/>	<input type="checkbox"/>	

Please list any other medical problems for which you are being treated _____

Patient Signature: _____ Date: _____

Name: _____ Date: _____

Physician Signature: _____ Date: _____