Goshorn Aesthetics

GOSHORN AESTHETICS
1364 CORDOVA CV.
GERMANTOWN | TN
901.682.4456

PATIENT INFORMATION
(please print)

Patient Name: _____ Home Phone: ( ) _____
Address: _____ City: _____ State: _____ Zip: _____
Sex: _____ Birthdate: ___/___/___ Age _____ Height _____ Weight _____ Marital Status: M S W D
Cell Phone: _____ Patient Email: _____
Employer: _____ Occupation: _____
Employer Address: _____ City: _____ State: _____ Zip: _____
Work Phone ( ) _____
What is the reason for your visit? (specify) _____
How long have you had this problem? _____
Referred by: (please circle) Physician, Family, Friend, Website, Google
Name: _____ Address: _____
City: _____ State: _____ Zip: _____
May we thank them for referring you? YES NO
Primary Care Physician: _____ Phone: _____
Pharmacy: _____ Phone: _____

GUARANTOR INFORMATION (Responsible Party/Policy Holder)

Relationship to patient: spouse mother father self other
Guarantor: _____ In care of: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: ( ) _____ Birthdate: _____/_____/_____
Cell Phone: ( ) _____ Email: _____
Employer: _____ Occupation: _____
Work Phone: ( ) _____ Address: _____
City: _____ State: _____ Zip: _____

EMERGENCY CONTACT (NOT LIVING AT ABOVE ADDRESS)

Next of Kin or Other: _____ Relationship: _____
Home Phone: ( ) _____ Occupation: _____
Work Phone: ( ) _____ Cell Phone: ( ) _____

INSURANCE INFORMATION

Primary Insurance
Insurance Company: _____
Group #: _____
Policy #: _____
Policy Holder Name: _____
Insurance Co. Phone #: _____

Secondary Insurance
Insurance Company: _____
Group #: _____
Policy #: _____
Policy Holder Name: _____
Insurance Co. Phone #: _____

Drug Allergies

Age	Drug Allergy	Type of Reaction

Medications taken, including vitamins, herbal or other over the counter medications

	Current Medication Name	Dose	Freq.	Prescribing Physician	Reason Medication Is Taken
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Do you take Coumadin, Warfarin, Aspirin, or Plavix? (circle one) **YES** **NO**

PRINT PATIENT'S NAME: **DATE:**

DATE OF BIRTH:

Pharmacy Name: _____ Phone Number: _____

Do you have any allergies other than medication? YES NO

If yes, list any allergies other than medications and the type of reaction(s): _____

_____

Have you ever had local anesthesia for dental work or minor surgery? If so, did you experience any reaction?

_____

Do you smoke? If so, how many packs per day? _____ Have you quit? _____ How long ago? _____

Do you chew tobacco or Nicorette gum? YES NO Do you use nicotine patches? YES NO

Have you ever had any significant medical events, illnesses or surgeries?

Date: _____ Type: _____ Date: _____ Type: _____

Date: _____ Type: _____ Date: _____ Type: _____

Date: _____ Type: _____ Date: _____ Type: _____

Date: _____ Type: _____ Date: _____ Type: _____

FAMILY HISTORY

Has any member of your immediate family ever had:

Heart Disease:	YES	NO	Relationship: _____
Tuberculosis:	YES	NO	Relationship: _____
Diabetes:	YES	NO	Relationship: _____
Stroke:	YES	NO	Relationship: _____
Cancer:	YES	NO	Relationship: _____
Birth Defects:	YES	NO	Relationship: _____

HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE?

(Please circle symptoms that apply)

YES	NO	
☐	☐	SLEEP APNEA
☐	☐	HEAD & NECK – eye, ear, nose or throat trouble
☐	☐	LUNGS – allergies or asthma, shortness of breath, chronic cough
☐	☐	HEART – chest pain, high or low blood pressure, rheumatic fever, bled excessively after injury or tooth extraction
☐	☐	ABDOMEN – stomach or intestinal problems, hepatitis or jaundice, kidney or bladder trouble, recent weight loss or weight gain
☐	☐	NERVOUS SYSTEM – headaches, dizziness, fainting, paralysis, numbness, head injury, seizures, nervous trouble of any sort
☐	☐	SKIN – skin disease, growth, tumor, cyst or cancer
☐	☐	PSYCHIATRIC – symptoms of anxiety, depression, or other psychiatric disease

If yes, please explain: _____

_____

_____

Additional History or Remarks: _____

_____

_____

NOTICE OF PRIVACY PRACTICES

I hearby acknowledge receipt of: Goshorn Aesthetics privacy practices. (if you would like a copy, please ask for the Compliance Officer).

Adult Patient/Guarantor: _____ Date: _____

FINANCIAL POLICY

Unless prior arrangements have been made with your doctor, we ask for full payment for your office care at the time office services are rendered. We accept cash, cashiers check, money order, personal check, Mastercard, Visa, or American Express. As a service, to you, we will be happy to file an insurance claim for you.

It is the policy of this office to collect the patient's deductible if it has not been met for the calendar year before surgical procedures are performed. For procedures covered by your insurance we will submit a claim to your insurance company, and once the company has paid its portion of the bill, the adult patient (18 years of age or older) or guarantor is responsible for any remaining balance. Any services not covered by insurance plans are to be paid in full prior to surgery.

If you find your insurance plan does not cover certain services or that it pays below our usual charge, we encourage you to discuss this with your insurance carrier. We have taken great care in setting our charges well within the acceptable normal for similar services available in this area. It is our desire that you receive the maximum benefit possible from your health insurance.

We ask you to inform us if your individual coverage has any special requirements for laboratory or hospitalization, the selected medical facility or laboratory will have no choice but to bill you directly for those charges. We ask you to remember that the ultimate responsibility for full payment of our services rest with the adult patient or guarantor (inclusive of any collection fees).

There is a processing fee of $35.00 on all returned checks.

I have read & understand this explanation of the financial policy of Goshorn Aesthetics. I agree to accept responsibility as described.

Adult Patient/Guarantor: _____ Date: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize, Goshorn Aesthetics, to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Adult Patient/Guarantor: _____ Date: _____

MEDICARE CERTIFICATION

I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Goshorn Aesthetics or services rendered me by its physician.

Patient or Representative: _____ Date: _____

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Result Notification Release

Patient: _____ Account #: _____

_____ Date: _____
Patient Signature

When notifying me of information relating to appointments, surgery times or place, financial, and/or test results, my Physician or a representative will:

Leave messages on my voice mail? Yes No N/A

Leave messages with my spouse? Name: _____ Yes No N/A

Leave messages with a family member? Yes No N/A

Specify name/s of family member(s) or ALL _____

_____

Call you at work? _____ Yes No N/A

Leave messages on my work voicemail? Yes No N/A

Are there any other ways to reach you that we should know about?

Cell Phone: _____

Cell phone text message: Yes No

Email: _____

Is there anyone else that we may talk to about your condition or arrangements?

_____

Are there any other special notification instructions we should know about?

_____

_____

Would you like more information on any of the following? Please circle

Skincare

- Skincare products
- BOTOX
- Injectable Fillers
- Coolsculpt
- Sclerotherapy for Leg Veins
- Facials

Lasers

- Age Spots
- Red Vessels
- Rosacea
- Hair Reduction

Procedures

- Facelift
- Browlift
- Eyelid Surgery
- Breast Augmentation
- Breast Lift/Reduction
- Liposuction
- Tummy Tuck