REGIONAL PLASTIC SURGERY CENTER

Date of Appointment: _____

Referring Physician: _____

☐ *Denton Watumull, M.D.*
☐ *Bruce Byrne, M.D.*
☐ *Joshua Lemmon, M.D.*

PATIENT REGISTRATION

Section 1: PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Marital Status: Married _____ Single _____ Divorced _____ Separated _____ Widow _____

Sex: Female _____ Male _____ Date of Birth: _____/_____/_____ Age: _____

Social Security Number: _____ Driver's License Number: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____-_____ Alternate Number: (_____) _____-_____

Email: _____

Please add me to your email list for Events and Spa Specials: ☐ Yes ☐ No

Student Status: Full Time _____ Part Time _____ Not A Student _____

Section 2: INSURANCE

GUARANTOR (Primary Insured):

Last Name: _____ First Name: _____ Middle Initial: _____

Guarantor's Address if different from Patient's: _____

_____

Relation to Patient: _____ Sex: Female _____ Male _____

Home Phone: (_____) _____-_____ Driver's License Number: _____

E-mail: _____

Date of Birth: _____/_____/_____ Social Security Number: _____

Employer: _____ **Work Phone:** (_____) _____-_____

Address: _____

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

Employment Status: Full Time _____ Part Time _____ Not Employed/Retired _____

Occupation: _____

PRIMARY Policy/ID# _____

Group # _____

Effective _____

Copay _____

SECONDARY Policy/ID # _____

Group # _____

Effective _____

Copay _____

Patient Name _____ Date of Birth _____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize Denton Watumull, M.D., Bruce Byrne, M.D., and/or Joshua Lemmon, M.D. to furnish information to insurance carriers concerning my illnesses, accidents, and treatments, and also assign to them all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I also understand that any additional copay, coinsurance, and/or deductibles are due at the time of service.

This office will request a surgery deposit of $250.00. In case of overpayment, you will be refunded after your insurance pays the surgery bill. **ACCOUNT NOT PAID IN 90 DAYS WILL GO TO OUR COLLECTION AGENCY.**

REGIONAL PLASTIC SURGERY CENTER NO-SHOW POLICY:

Our policy is to charge $50 for no-shows to office appointments if we do not have 24-hour notification of cancellation; and $100 for no-shows to office surgery if we do not have 48-hour notification of cancellation.

Signature: _____ Date: _____
(Patient's signature or responsible party)

I (We) voluntarily request Dr. _____ as my physician, and such associates, technical assistants, and other health care providers they deem necessary.

Signature: _____ Date: _____
(Patient's signature or responsible party)

Section 3: EMERGENCY CONTACT (Any person not residing with patient)

Name: _____ Relation to Patient: _____

Address: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

E-mail _____

CONTACT CONSENT

I, _____ the undersigned patient, authorize Regional Plastic Surgery Center to contact me at the following numbers:

A). Via Phone:				**Can Leave Message:**	
At Home:	Yes _____	No _____	Number: (_____) _____-_____	Yes ____	No ____
At Work:	Yes _____	No _____	Number: (_____) _____-_____	Yes ____	No ____
Cell Phone:	Yes _____	No _____	Number: (_____) _____-_____	Yes ____	No ____

B). Other Persons We May Leave A Message With:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name _____ Date of Birth _____

Section 4: NEW PATIENT INFORMATION

Age: _____ Are you RIGHT or LEFT handed? (circle one) R L

Reason for Today's Visit: _____

_____

Date of Injury (if applicable): _____ Height: _____ Weight: _____

Prior treatment or studies for this problem: _____

_____

_____

Referred by: _____ Primary Doctor: _____

PAST MEDICAL HISTORY

Melanoma	___ Yes ___ No	Cancer	___ Yes ___ No	Kidney Disease	___ Yes ___ No
Heart Disease	___ Yes ___ No	Asthma	___ Yes ___ No	Thyroid Disease	___ Yes ___ No
Stroke	___ Yes ___ No	AIDS or HIV	___ Yes ___ No	Bleeding Tendency	___ Yes ___ No
Anemia	___ Yes ___ No	Hepatitis	___ Yes ___ No	High Blood Pressure	___ Yes ___ No
Tuberculosis	___ Yes ___ No	Gout	___ Yes ___ No	Mitral Valve Prolapse	___ Yes ___ No
Diabetes	___ Yes ___ No	High Cholesterol	___ Yes ___ No	Bad Scarring/Keloids	___ Yes ___ No
Lung Problems	___ Yes ___ No	Stomach Ulcer	___ Yes ___ No		

Do you have SLEEP APNEA? ___ Yes ___ No

Have you had BLOOD CLOTS (DVT, pulmonary embolism)? ___ Yes ___ No

Other conditions/problems: _____

_____

PRIOR OPERATIONS:

Tonsillectomy	___ Yes ___ No	Gastrointestinal	___ Yes ___ No	Hand or arm	___ Yes ___ No
Appendectomy	___ Yes ___ No	Hysterectomy	___ Yes ___ No	Heart	___ Yes ___ No
Kidney/Bladder	___ Yes ___ No	Hernia Repair	___ Yes ___ No		

Other operations: _____

_____

FAMILY HISTORY

Breast Cancer	___ Yes ___ No	High Blood Pressure	___ Yes ___ No	Depression	___ Yes ___ No
Heart Disease	___ Yes ___ No	Diabetes	___ Yes ___ No	Bleeding problem	___ Yes ___ No
Arthritis	___ Yes ___ No	Kidney Disease	___ Yes ___ No		

_____

Do you smoke? ___ Yes ___ No How much? _____ How many years? _____

If you quit smoking, when did you quit? _____

Do you drink alcohol? ___ Yes ___ No If yes, ___rarely ___socially ___daily ___heavily

Do you take any non-prescription or illicit drugs? ___ Yes ___ No

Patient Name _____ Date of Birth _____

Do you have any of the following problems?

Weight change	___ Yes ___ No	Swollen feet	___ Yes ___ No	Seizures	___ Yes ___ No
Dry eyes	___ Yes ___ No	Skin rash	___ Yes ___ No	Joint/muscle pain	___ Yes ___ No
Chronic cough	___ Yes ___ No	Chronic diarrhea	___ Yes ___ No	Swollen lymph nodes	___ Yes ___ No
Chest pain	___ Yes ___ No	Jaundice	___ Yes ___ No	Easy bleeding	___ Yes ___ No
Rapid heartbeat	___ Yes ___ No	Depression	___ Yes ___ No	Easy bruising	___ Yes ___ No
Shortness of breath	___ Yes ___ No				

Do you have any medication allergies? ___ Yes ___ No
(Hives, welts, severe itching, facial/oral/airway swelling)

If yes, please list: _____

Do any medications cause adverse side effects for you? ___ Yes ___ No
(Nausea, vomiting, dizziness, stomach discomfort, confusion)

If yes, please list: _____

List all current medications (including over-the-counter/herbal):

Are you currently working? ___ Yes ___ No Job Title _____
If yes, in what capacity? ___ Full duty ___ Light duty
Do you have any current work restrictions? ___ Yes ___ No
If yes, please explain: _____

Reviewed: _____
Sign/Date

Dr. Watumull Dr. Byrne Dr. Lemmon

Patient Name _____ Date of Birth _____

REGIONAL PLASTIC SURGERY CENTER & Spa

Date: _____

TO WHOM IT MAY CONCERN:

I authorize the release of all my medical records with your office to

☐ Dr. Denton Watumull ☐ Dr. Joshua Lemmon

☐ Dr. Bruce Byrne

LOCATIONS:

☐ Richardson ☐ Rockwall ☐ Las Colinas

A photocopy of this will be considered as valid as the original.

_____
Patient Signature (or guardian)

3201 E. President George Bush Frwy, Ste. 101
Richardson, Texas 75082
(972) 470-5000
fax (972) 470-5007

1407 Ridge Road, Ste. 101
Rockwall, Texas 75087
(972) 470-1000
fax (972) 772-9561

6750 N. MacArthur, Ste. 257
Irving, Texas 75039
(972) 401-0867
fax (972) 470-5007

Patient Name _____ Date of Birth _____

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants
of the Texas State Board of Medical Examiners,
including physician assistants and acupuncturists,
may be reported for investigation to the following address:

Texas State Board of Medical Examiners
Attn: Investigations
Centre Creek Drive, Suite 300
Austin, TX 78714-9134

1-800-201-9353