**GULF COAST AESTHETIC CENTER**

 **Patient History & Information (PHI)**

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PATIENT #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT’S NAME**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARITAL STATUS: M S W D

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_ST: \_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WORK PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**CELL**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMAIL ADDRESS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AGE: \_\_\_\_\_\_\_ **BIRTHDATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_ SEX: \_\_\_\_ M \_\_\_\_ F **SOCIAL SECURITY**#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER ADDRESS & PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EXT \_\_\_\_\_\_\_\_\_\_\_\_\_

**SPOUSE OR GUARDIAN NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BIRTHDATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NAME,** ADDRESS & **PHONE NUMBER** OF NEAREST RELATIVE (OR FRIEND) **NOT** LIVING WITH YOU:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERRED BY** (DOCTOR, HOSPITAL, FRIEND, YELLOW PAGES, NEWSPAPER, RADIO, WEB SITE, ETC.)

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NAME OF **INSURANCE** COMPANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME & LOCATION OF **PHARMACY** YOU USE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Why are you here seeing the doctor?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Injury, what date did it happen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DO YOU SMOKE**? \_\_\_\_\_\_\_\_\_\_\_\_\_ **IF YES, HOW MUCH** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

KNOWN MEDICAL PROBLEMS & NAME OF PHYSICIAN TREATING YOU: (**DIABETES, HIGH BLOOD PRESSURE, HEART DISEASE, ETC.**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PAST MAJOR SURGERIES PERFORMED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*DAILY MEDICATIONS** (INCLUDE **ASPIRIN, ANTI-INFLAMMATORIES, VITAMIN E, HERBAL SUPPLEMENTS**)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ARE** **YOU CURRENTLY TAKING DIET PILLS?**\_\_\_YES / NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*ARE YOU ALLERGIC TO ANY MEDICATIONS? (EITHER MARK NONE OR LIST THEM)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**RESPONSIBLE PARTY (IF OTHER THAN PATIENT)**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO PATIENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_ST: \_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SEX: \_\_\_\_ M \_\_\_\_ F SOCIAL SECURITY# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTHDATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WORK PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ERIC J. WYBLE, M.D.**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSONAL HISTORY**

Do you smoke? \_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_How long have you smoked? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you smoked in the past, when did you stop? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much alcohol do you drink on the average per day or week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you on a special diet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What diet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you recently gained or lost weight? Gained\_\_\_\_\_\_\_\_\_\_ Lost\_\_\_\_\_\_\_\_\_\_\_ N/A \_\_\_\_\_\_\_\_\_\_\_\_\_

OPERATIONS:

Have you had any of the following:

 No Yes Date

Tonsils \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appendix \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gallbladder \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Small Intestine \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colon \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hemorrhoid \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hernia (rupture) \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Uterus \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ovaries \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prostate \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Surgery \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FAMILY HISTORY**:

Have you or any member of your family had any of the following?

 Yourself / What Relative

Cancer/Leukemia N Y \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tuberculosis N Y \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes N Y \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Trouble N Y \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure N Y \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke N Y \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Epilepsy N Y \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding Disorder N Y \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma N Y \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Migraine Headaches N Y \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcoholism N Y \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emphysema N Y \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Disease N Y \_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sickle Cell Anemia N Y \_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anemia N Y \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Illness N Y \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suicide N Y \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Serious Disease N Y \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so, what: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ERIC J. WYBLE, M.D**.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

Please fill in the appropriate information; for acknowledgement of Notice:

 i, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (Patient’s Name)

have read and understand Eric J. Wyble, M.D.’s—gulf coast aesthetic center, llc’s, notice of Privacy Practices in accordance with hippa laws at this time.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient’s Signature Date

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Witness’s Signature Date

  **\*I authorize you to share my medical information with the following person/s:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date: This notice is effective June 26, 2009

**ERIC J. WYBLE, M.D.**

**AUTHORIZATION**

**(MUST BE SIGNED BEFORE SEEN BY THE PHYSICIAN)**

I UNDERSTAND THAT, ALTHOUGH THE PHYSICIAN’S OFFICE MAY FILE A CLAIM TO MY INSURANCE COMPANY AS A COURTESY TO ME, I AM FULLY RESPONSIBLE FOR PAYMENT IN FULL FOR ANY SERVICES RENDERED. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO VERIFY THAT DR. ERIC WYBLE/DR. JOHN H. MILLER IS CONTRACTED WITH MY INSURANCE COMPANY AS WELL AS ANY SURGICAL CENTER WHERE SERVICES ARE RENDERED. SHOULD MY ACCOUNT BECOME DELINQUENT ANY EXPENSES INCUREED BY THE PHYSICIAN’S OFFICE BY REQUIRING THE AID OF AN ATTORNEY, COLLECTION AGENCY, CREDIT BUREAU, ETC., A 33% SERVICE FEE MY BE ADDED TO MY ACCOUNT FOR ANY UNPAID BALANCE.

 I AUTHORIZE YOU TO RELEASE TO MY INSURANCE COMPANY (INCLUDING MEDICARE AND ANY MEDIGAP, IF APPLICABLE) ANY INORMATION REGARDING MY ILLNESS OR TREATMENT AND I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR SERVICES RENDERED TO MYSELF OR MY DEPENDENTS.

I AUTHORIZE THE PHYSICIAN’S OFFICE AND/OR HIS HEALTH CARE PROVIDERS TO TAKE PREOPERATIVE, INTRAOPERATIVE, AND POSTOPREATIVE PHOTOGRAPHS, SLIDES, AND/OR VIDEO TAPES (IF APPLICABLE).

I CERTIFY THAT MY SIGNATURE REPRESENTS THAT I HAVE READ AND AGREE TO THE ABOVE INFORMATION. I HAVE HAD THE OPPORTUNITY TO ASK ANY QUESTIONS AND HAVE DONE SO WITH ALL QUESTIONS ANSWERED AND UNDERSTOOD.

**Narcotic Prescription Policy**

It is our office policy to **not authorize** refills in the evenings or on the weekend (Friday thru Monday). If you are out of your narcotic medication then please proceed to your nearest Emergency Department. State and federal laws forbid early refills in narcotic medication in the absence of an emergency situation or change in prescription. *Therefore, when you notice you have only a small amount of medication remaining, please inquire from your physician for a refill at your next office visit or during regular office hours.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT’S SIGNATURE (OR GUARDIAN) DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS