**A. E. HAAS, M.D.**
**Plastic and Reconstructive Surgery**
**Venice Wound Center, Specialty Wound Care**

Patient Name: Last____________________ First________________ MI___ Birth Date______________ Sex __M __F
Patient **Local**
Addresses__________________________________________________ City____________________________

State______________ZIP______________Phone ( ) _____________ Cell Ph # __________________

**Out of Town Address**________________________________________ City____________________________

State______________ZIP______________Phone ( )_________________

Patient Social Security #________________________ Marital Status: __S __M __W __D
If above is a minor, parent/guardians's SSN: _________________________

Person Responsible
for Payment of Bill_______________________________Relation to Patient_________________ Birth Date______________

Address of Above Person_______________________________________ City____________________________

State______________ZIP______________Phone ( )_________________

**My initial visit today will be paid by:** __ CHECK, I have my checkbook in hand

__ Cash, I have adequate cash on hand

__ VISA or __ MasterCard or __ American Express - I have my card in hand

Patient Spouse or
Nearest Relative________________________________Relation to Patient_________________ Birth Date______________

Address of Above Person_______________________________________ City____________________________

State______________ZIP______________Phone ( )_________________

Patient's Occupation _______________________ If retired, previous occupation or trade: _____________________________

Patient's Employer _________________________________________ Address_______________________________________

City__________________ST____________ZIP__________Phone ( )_________________ Country___________

**Medicare or other**
**Primary** Insurance
Company Name____________________________________
Policy #_________________________Group #____________
Claims Office Name_______________________________
Address__________________________________________
City__________________________State________________
ZIP____________ Phone ( )_____________________

**Name** of policy holder______________________________
Date of birth of policy holder__________________________
Deductible Amount $___________

**Secondary**
Insurance
Company Name____________________________________
Policy #_________________________Group #____________
Claims Office Name_______________________________
Address__________________________________________
City__________________________State________________
ZIP____________ Phone ( )_____________________

**Name** of policy holder______________________________
Date of birth of policy holder__________________________
Deductible Amount $___________

PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION (Including HIV) AND CLAIM PAYMENT AUTHORIZATION:
I hereby authorize the above physician to release any information by phone, letter or FAX regarding services rendered by him and a photocopy of my signature to be used to file insurance. I also authorize medical photographs to be taken for patient medical records. I agree to pay any assessments to the bill incurred if collection problems occur. I authorize and direct any medical payments to be made directly to the physician and I am financially responsible for all fees for services rendered. I authorize other physicians offices to forward medical records to Dr. Haas' office as needed. The doctor may speek to any person for my care including other physicians offices and doctors to forward medical records to Dr. Haas' office as needed.

**Date**_________ Signature X______________________________
__Patient ___Parent if minor or Guardian

**Insurance companies always reimburse less than you would expect. Ask about your fees.**

List medicines you are allergic to:

List your current medicines: | Dose & frequency

Date -last Tetanus shot: Date:

All previous surgeries: Dates:

| | Yes | No |
|---|---|---|
| Do you drink alcohol? | | |
| per/day____________ | | |
| per/week___________ | | |
| Do you smoke | | |
| Packs/day_______ | | |

Have you had any of the following:

| | Yes | No |
|---|---|---|
| Stroke | | |
| Epilepsy/convulsions | | |
| Migraine | | |
| Rheumatic fever | | |
| Leukemia | | |
| Tuberculosis or TB | | |
| Bronchitis | | |
| Emphysema | | |
| Pneumonia | | |
| Asthma | | |
| Hay Fever | | |
| Lung Disease | | |
| Shortness of Breath | | |
| Frequent nose bleeds | | |
| Bleeding Problems | | |
| Anemia | | |
| Diabetes | | |
| Hepatitis | | |
| Liver Disease | | |
| Jaundice | | |
| Kidney disease | | |
| Arthritis | | |

| | Yes | No |
|---|---|---|
| Back pain or injury | | |
| Slipped disc | | |
| Thyroid problems | | |
| Ulcers | | |
| Psychiatric Problems | | |
| AIDS / HIV | | |
| High Blood Pressure | | |
| Heart murmur | | |
| Chest Pains/Angina | | |
| Heart attack(s) | | |
| Anesthesia Problems | | |
| Skin Cancer | | |

Other Cancer-
List:

Any other illnesses.
List:

Family History:

Explanation of above findings:______________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

**Todays date:**_________ Your age ______ Height _______ Weight _______ Right handed__ or Left handed__

Reason for Consultation: __Work injury __Auto Accident __Cosmetic __Other___________________________

What is the Injury or Problem________________________________________________________________

______________________________________________________________________________________

Date Injured _____________ or **About when** was problem first noticed_______________________________

What Physician or Person Referred you ___________________________ or __Self Referral

** How did you find out about us? __Doctor or __Friend-Who?______________ __Yellow pages : __ Sarasota __ Venice __ Englewood

Internet Web Page ___

Hospital referral service: __Venice __Englewood __ Emergency room : __Venice __Englewood

Hospital Brochure:__Venice __Englewood __Newspaper __TV __Lecture series

Name of your **family doctor** ________________________
If you do not have a regular family doctor, we ***strongly*** urge you to get one for routine exams and referrals to appropriate doctors when needed.

**Your local pharmacy** is _________________________________ Phone_______________ Location_____________________
We try to maintain privancy but people will see your name on our sign up sheet at the front office. If this is not OK with you then do not sign in and let us know that you are here but not signed up. It is also possible that another person may see your chart lying on a desk. We make every attempt to keep others from seeing the contents.