MICHELLE J. PLACE, MD., F.A.C.S
100 Park Place, Suite 240
San Ramon, CA 94583 (925) 837-1347

Patient Name: _____
Last First Middle

Address: _____
Street City State ZIP

Home phone: _____ Cell phone: _____ Email: _____

Do you have any contact restrictions: _____

Birthdate: ___/___/___ Age: _____ SS: _____

Gender: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Other

Who referred you to our office: _____

Employment

Name of employer: _____ Occupation: _____

Work phone: _____ Ext: _____

Contact restrictions at work: ☐ Yes ☐ No

Address: _____
Street City State ZIP

Emergency Contact Details

Name of contact person: _____ Relationship to patient: _____

Home phone: _____ Work phone: _____

Primary Health Insurance Company

Name of Primary Insurance: _____ Ins Phone _____

ID #: _____ Group #: _____ Co-pay amount: _____

Name of primary insured: _____ DOB: _____ SS #: _____

Relationship to patient: _____

Secondary Health Insurance

Name of Secondary Insurance: _____ Ins Phone _____

ID #: _____ Group #: _____ Co-pay amount: _____

Name of secondary insured: _____ DOB: _____ SS #: _____

Relationship to patient: _____

I understand that office visit charges are payable on the day that services are rendered. I authorize Dr Place to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr Place and myself

SIGNATURE: _____ **DATE:** _____

MEDICAL HISTORY AND HEALTH QUESTIONAIRE

1. How would you describe your general health? ☐Excellent ☐ Average ☐Poor

2. Height_____ Weight_____

3. Date of last medical examination:_____

4. List previous surgeries you have had and the date you had the surgery/surgeries:

_____

_____

_____

5. Are you taking any medications or drugs at present? If so, what?_____

_____

6. Do you smoke?_____If so, how much?_____

7. Allergies? To what?_____

Do you have or have you ever had any of the following:

	YES	NO
Heart disease		
Shortness of breath with limited activity Or when resting?		
Chest pain or angina pectoris		
Heart attack		
Rheumatic fever or rheumatic heart disease		
Heart murmor		
Heart defect from birth		
High blood pressure		
Fainting spells, convulsions or epilepsy		
Lung disease (tb, asthma, jaundice, cirrhosis or other)		
Liver disease (hepatitis,		

jaundice,cirrhosis or other)		
Kidney disease		
Diabetes		
Prolonged bleeding following injuries or surgery		
Skin diseases		
Psychiatric problems eg depression		

8. Do you have any family history of these diseases? Please explain

_____

_____

.9. Did you get referred to our office by a physician?_____

If so, please provide the name of the physician_____

City of referring physician_____

10. Do you now or have you in the past month taken any aspirin? _____

11. Is there anything of importance in your medical history that has not been asked?

_____

_____

12. Explain:_____

I HEREBY GIVE MY PERMISSION TO M.J. PLACE, M.D. TO ADMINISTER ANY TREATMENT; OR TO ADMINISTER SUCH ANESTHETICS; AND TO PERFORM SUCH OPERATIONS THAT MAY BE DEEMED NECESSARY OR ADVISABLE IN THE DIAGNOSIS AND TREATMENT OF THE PATIENT NAMED BELOW.

PATIENT SIGNATURE : _____ **DATE:**_____

_____RELATIONSHIP_____

(SIGNATURE OF PATIENT OR NEAREST RELATIVE)

AUTHORIZATION MUST BE SIGNED BY THE PATIENT, OR BY THE NEAREST RELATIVE IN THE CASE OF A MINOR OR WHEN THE PATIENT PHYSICALLY OR MENTALLY INCOMPETENT.

Michelle J. Place, MD
100 Park Place Suite 240
San Ramon, CA 94583

CONSENT FOR PATIENT PRIVACY

The office of Michelle J. Place, MD consents to protecting your privacy by keeping all your health care information confidential.

I consent to Michelle J. Place, MD and all furnishing care providers furnishing care within the office of Michelle J. Place, MD. to protect my health care information. Furthermore, I consent to the disclosure of my protected health information for the purposes of treatment, payment and health care operations to facilities such as laboratories, hospitals etc.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the below mentioned address. This may be delivered in person or by mail, but it will be only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent. We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by calling our office.

Patient Name:_____

Signature_____Date_____

If you are signing as the patient's representative:

Full Name_____Signature:_____

FINANCIAL POLICY OF MICHELLE J. PLACE, MD

FOR INSURABLE OFFICE VISITS OR PROCEDURES

- ***It is the responsibility of the patient to verify that Dr Place is a contracted provider with your insurance company.***

- Your co-pay is due at the time of service otherwise you may be asked to reschedule your appointment.

- If you receive a statement in the mail and your account is past due, a late fee of $5.00 will apply. Any accounts that are overdue for 90 days will be forwarded to collections.

- It is *your* responsibility to call your insurance company and verify that we are a contracted provider with your insurance otherwise you will be held responsible for the procedure or office visit.

- Medicare patients will be asked to sign an Advanced Beneficiary Notice prior to procedures (refers to you being financially responsible for your service/procedure if your insurance refuses to pay for it)

FOR COSMETIC OFFICE VISITS OR PROCEDURES

- Your initial consultation is complimentary for cosmetic procedures. (Please note that if you want Dr Place to determine whether your procedure and/or surgery will be covered by your insurance, your office visit will be billed to your insurance and you will be held accountable for your co-payment portion).

- If you have scheduled surgery, we require payment one week prior to surgery or at the time of your pre-operative appointment. (This will be indicated in your pre-surgical package).

- For skin care patients, a 24-hour notice is required for cancellations of your appointments otherwise a charge of $30.00 will be charged.

I understand and have read the financial policy of Dr Michelle Place and agree to comply with the above policy

Patient Name:_____*Patient Signature*_____