REGISTRATION
(PLEASE PRINT)

Hermosa Plastic Surgery
8004 Constitution Place NE
Albuquerque, NM 87110
(505) 924-2225

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Patient Questionnaire

1. Are you worried about how you look? Yes No
2. Do you think about your appearance all the time and wish you could think about it less? Yes No
3. Please list the body areas you do not like:

   _____

   _____

   _____

   _____

4. How many plastic surgeons have you seen?

   _____

5. Have you had plastic surgery before?

   _____

6. Were you satisfied with your prior plastic surgery?

   _____

7. Is your main concern, that you aren't enough or that you may get too fat? Yes No
8. How has this problem with how you look affect your life?

   _____

   _____

9. Has it often gotten in the way of doing things with friends or dating? Yes No
   (If yes please describe)

   _____

10. Has it caused you any problems with school or work? Yes No
    (If yes, please describe)

    _____

11. Are there things you avoid because of the way you look? Yes No
    (If yes, please describe)

    _____

12. On an average day, how much time do you usually spend thinking about how you look? (Add up all the time you spend in a day, and then circle one.)
    A. Less than 1 hour a day
    B. 1-3 hours a day
    C. More than 3 hours a day

Hermosa Plastic Surgery
Miguel L. Gallegos M.D.
8004 Constitution Pl NE
Albuquerque, NM 87110
Phone: (505) 924-2225
Fax: (505) 924-1063

Medical Photographs/ Video Tapes/ Slides
May be taken before, during or after any surgical procedure or treatment.
Consent is required to take such images.

1. **Consent to take photographs/slides/video tapes**

   I hereby authorize Dr. Miguel L. Gallegos M.D. and his associates or licensees to take pre-operative, intra-operative, and post-operative photographs.

2. **Consent for release of photographs/slides/video tapes**

   I hereby authorize Dr. Miguel L. Gallegos M.D. and his associates or licensees to use pre-operative, intra-operative, and post-operative photographs or video tapes for professional medical purposes deemed appropriate for medical education, patient education, lay publication or during lectures to medical lay groups.

   I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/ or my interview.

Date: _____

Patient Print Name: _____

Patient Signature: _____

Witness: _____

Patient Consent for use of Credit, Debit Card, and Financing-Disclosure of Protected Health Information

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies when requested to facilitate your payment.

Services that are preformed and are paid with a credit card, debit card or financing third party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Dr. Gallegos to use and disclose my protected health information to any credit card entity, bank, or financing company when requested to such information to process an account and assist with payment.

_____ (initial) I will not challenge such credit, debit, bank or financing card payments once the services have been provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.

_____ (initial) I agree that his noncredit card challenge agreement is irrevocable.

X_____ (patient signature)

Acknowledgement of Receipt of Notice

Miguel L. Gallegos, MD
8004 Constitution Pl. N.E.
Albuquerque, NM 87110
(505) 924-2225

I hereby acknowledge that I read a copy of this medical practice's HIPPA Patient Rights.

I would like to receive a copy of any amended Notice of Privacy Practices by sending a request to Stacy Taylor, Privacy Officer, at the above address and phone number.

Yes_____ No_____

Signed: _____ Date: _____

Printed Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship to patient.

- Patient or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: _____

For office use Only:

Signed form received by: _____

Acknowledgement refused:

Efforts to obtain/ reasons for refusal:

_____

_____