Quincy Plastic Surgery & Aesthetics

Welcome to the office of Paige C. Holt, MD & Glori Traeder, APRN.
Please take this time to become acquainted with the policies of our practice. You are at the core of all that we do. Our goal is to provide you with exceptional care each and every visit. In order to maintain our goal, we have highly trained staff available to help answer any questions you may have.

Your First Step: Please download and complete the New Patient Forms ahead of time. You may fax the completed forms to our office at (217) 214-8200 or email them to *info@quincyilplasticsurgery.com*. If you are unable to complete these forms prior to your appointment, please arrive 5-10 minutes early to complete them.

If you have a consultation scheduled, please expect to spend about an hour at our office. When you arrive for your appointment, you will be welcomed into a private treatment suite. During this time we will create a personalized treatment plan with you based on your concerns and educate you on your options.

Our experts have years of experience in performing this treatment, ensuring that you get the best results possible. We will work with you to understand your aesthetic goals and come up with a personalized treatment plan that is right for you.

What to bring for you first appointment:

1. *New Patient Registration Forms*
2. *Photo ID*
3. *List of medications*

Directions and Map ›

In our desire to be effective and fair to our employees and patients, please honor the following policies:

Appointment Policy: Non-surgical consultations must be secured with a credit card. Our highly-skilled team plan their appointment times to provide each client with expert care and undivided, unhurried attention. We ask that you kindly give us 24 hours notice to cancel or reschedule an appointment.

> *If you are unable to give us advance notice or you miss your consultation appointment. We reserve the right to charge a "no show" cancellation fee of $75. This will result in the temporary suspension of services until the fee has been paid. Another $75 deposit will be required to schedule a future appointment.*

Of course, we understand that unanticipated events happen occasionally. Please contact us if you believe there was an error. By scheduling an appointment, you agree to our appointment policy. If you don't fall within our policy guidelines, your credit card will be charged.

Late arrival: Arriving late to an appointment may result in a shortened session to accommodate scheduled appointments thereafter. *Depending upon how late you arrive, the appointment may have to be rescheduled.*

Financial Policy: All professional services and products are charged directly to the patient. The patient is responsible for fees. **IMPORTANT: Checks are not accepted for products and nonsurgical services.** Cash, all major credit cards, Care Credit and Alphaeon Financing are accepted. Please contact us for more information.

I have read to the above policy and agree to comply with its provisions. I understand that I am responsible for payment for all services rendered. I understand that if I am covered by a third party payment service, such as Care Credit, I am personally responsible for such charges until they are paid in full.

_____ _____

Signature *(Patient or Parent/Guardian if patient is under 18)* Date

707 N 24th St | Quincy IL | 62301
Phone: (217) 214-8282 | Fax: (217) 214-8200

Paige C. Holt MD
Quincy Plastic Surgery & Aesthetics

Personal Information

Date: _____ Name: _____

Date of Birth: _____ Age: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Please check the ways in which you consent to communicate:

Primary Phone: (_____) _____ - _____ ☐ Call? ☐ Text? ☐ Voicemail? ☐ Appointment reminders?

Email address: _____ ☐ Send email?

Emergency Contact Name & Phone: _____ Relationship: _____

How did you hear about us? _____

What is the nature of your visit? _____

Medical History

Primary care provider: _____ Height: _____ Weight: _____

Have you or do you still have: *(Please check all that apply.)*

☐ Cancer	☐ Asthma	☐ Skin Disease/Skin Lesions	☐ High Blood Pressure
☐ HIV/AIDS	☐ Heart trouble	☐ Neurologic Disease	☐ Pacemaker/Defibrillator
☐ Stroke	☐ Seizure Disorder	☐ Frequent Cold Sores	☐ Any Active Infection
☐ Diabetes	☐ Arthritis	☐ Hormone Imbalance	☐ Thyroid Imbalance
☐ Hepatitis	☐ Herpes	☐ Keloid / Problem Scarring	☐ Blood Clotting Abnormalities

☐ Others Not Listed: _____

Are you allergic to any medication, latex or local anesthesia? ☐ No ☐ Yes, please list with reaction: _____

_____

Have you ever had surgery? ☐ No ☐ Yes, please describe: _____

_____

_____

For Female Clients

Are you pregnant or trying to become pregnant? ☐ No ☐ Yes

Are you breastfeeding? ☐ No ☐ Yes

Medications

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list with dose and frequency:

_____

_____

_____

Social History

Do you smoke? ☐ No ☐ Yes, how much? _____

Previous smoking history? ☐ No ☐ Yes, how long ago? _____

Do you drink? ☐ No ☐ Yes, how much? _____

Do you regularly sun bathe or use tanning salons? _____ How Often? _____

Sun Exposure History: _____

Review of Systems

Do you now or have you had any problems related to the following systems? *Circle Yes or No*

Neurological:
- Numbness / Tingling in Arms or Legs Y N
- Dizziness Y N
- Frequent Headaches Y N
- Other _____

Psychiatric:
- Depression Y N
- Anxiety Y N
- Other _____

Gastrointestinal:
- Anorexia Y N
- Nausea/Vomiting Y N
- Abdominal Pain Y N
- Other _____

Endocrine:
- Hot / Cold Intolerance Y N
- Night Sweats Y N
- Other _____

Eyes:
- Blurred Vision Y N
- Visual Loss Y N
- Double Vision Y N
- Other_____

Skin:
- Itchy skin Y N
- Rash Y N
- Hives Y N
- Other _____

Hematologic:
- Anemia Y N
- Bruising Y N
- Bleeding Y N
- Other _____

Musculoskeletal:
- Muscle Pain Y N
- Back Pain Y N
- Joint Pain Y N
- Other _____

Constitutional symptoms:
- Fever Y N
- Chills Y N
- Headache Y N
- Other _____

Ears, Nose, Throat:
- Hearing Loss Y N
- Sneezing Y N
- Congestion Y N
- Other _____

Cardiovascular:
- Chest Pain Y N
- Shortness of Breath Y N
- Cough Y N
- Other _____

Lymphatics:
- Enlarged Lymph Nodes Y N
- Other _____

Genitourinary:
- Painful Urination Y N
- Urination Incontinence Y N
- Other _____

Family History

Have any blood relatives had any pertinent medical history including:

Cancer	☐ No	☐ Yes	Describe: _____
Bleeding Tendency	☐ No	☐ Yes	Describe: _____
Leukemia	☐ No	☐ Yes	Describe: _____
Heart Disease	☐ No	☐ Yes	Describe: _____
High Blood Pressure	☐ No	☐ Yes	Describe: _____
Repeated Infections	☐ No	☐ Yes	Describe: _____
Chronic Lung Disease	☐ No	☐ Yes	Describe: _____
Tuberculosis	☐ No	☐ Yes	Describe: _____
Asthma	☐ No	☐ Yes	Describe: _____
Severe Allergies	☐ No	☐ Yes	Describe: _____
Kidney Disease	☐ No	☐ Yes	Describe: _____
Arthritis	☐ No	☐ Yes	Describe: _____
Mental Illness	☐ No	☐ Yes	Describe: _____
Convulsions	☐ No	☐ Yes	Describe: _____
Migraine Headaches	☐ No	☐ Yes	Describe: _____
Diabetes	☐ No	☐ Yes	Describe: _____
Gout	☐ No	☐ Yes	Describe: _____
Thyroid Trouble	☐ No	☐ Yes	Describe: _____
Heart Surgery	☐ No	☐ Yes	Describe: _____
Obesity	☐ No	☐ Yes	Describe: _____

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

_____

Signature *(Patient or Parent/Guardian if patient is under 18)* Date

Paige C. Holt MD
Quincy Plastic Surgery & Aesthetics

Privacy Policy

This is the privacy policy of Quincy Plastic Surgery & Aesthetics. The entire staff works diligently every day to respect the privacy of your personal information. Please take a moment to familiarize yourself with what information we collect, how we protect it, and how we use it.

- The staff has been trained in the importance of maintaining your confidentiality and enforces the facility's privacy rules.
- We only collect information which is pertinent to providing you with quality care.
- We will maintain physical, electronic, and procedural safeguards to protect personal information we obtain about you.
- We will respect your expressed desire not to share certain information. You may so direct at any time.
- If at any time you should feel that your privacy is being compromised, please let the Practice manager know immediately.

Thank you for allowing Quincy Plastic Surgery & Aesthetics the opportunity to assist you in achieving your plastic, reconstruction and aesthetic surgery goals.
I acknowledge that I have received or been offered the **HIPPA Notice of Privacy Practices** of Quincy Plastic Surgery & Aesthetic effective July 1, 2015. I understand that the Notice describes the uses of my protected health information by the Covered Entities which collectively constitute Quincy Plastic Surgery & Aesthetics and informs me of my rights with respect to my protected health information.

_____

Name of Patient Date of Birth

_____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

If personal Representative, indicate relationship: _____

Declinations

_____ The Individual declined to accept a copy of the Notice of Privacy Practices.

_____ The Individual received a copy of the Notice of Privacy Practices, but declined to sign an Acknowledgement of Receipt.

Photograph Consent and Release

Photographs will be taken of me or parts of my body before and after surgery or a procedure. Paige C. Holt, MD and such assistants as may be selected to take photographs.

Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Quincy Plastic Surgery & Aesthetics. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Paige C. Holt MD Quincy Plastic Surgery & Aesthetics.

I, _____ hereby acknowledge my consent for photographs as detailed above. This consent may be revoked at any time by written request or completion of a new form.