Edmonson Aesthetic Facial Surgery, LLC ACCT#_____

Brenda Edmonson, M.D.

PATIENT INFORMATION

DATE:_____

FIRST NAME:_____M.I._____LAST NAME_____

MAIDEN/PREVIOUS NAME:_____SPOUSE:_____

EMAIL:_____

ADDRESS:_____

CITY:_____STATE_____ZIP:_____

D.O.B._____SEX:_____MARITAL STATUS:_____

S.S.N._____REFERRING PHYSICIAN_____

PRIMARY PHONE#_____SECONDARY PHONE#_____

EMERGENCY NAME AND PHONE#:_____

PATIENTS EMPLOYER:_____PHONE#_____

INSURANCE INFORMATION

PRIMARY INSURANCE_____POLICY NUMBER_____

GROUP NUMBER_____SUBSCRIBER NAME_____

RELATIONSHIP TO PATIENT_____D.O.B._____SEX:_____S.S.N._____

ADDRESS:_____PHONE:_____

SECONDARY INSUARANCE:_____POLICY NUMBER_____

GROUP NUMBER:_____SUBSCRIBER NAME_____

RELATIONSHIP TO PATIENT:_____ADDRESS:_____

PHONE NUMBER_____SEX:_____D.O.B._____S.S.N._____

PATIENT INFORMATION

DATE:_____

_____I ELECT TO OPT OUT AND NOT COMPLETE QUESTIONAIRE:_____

LAST NAME:_____FIRST NAME:_____

DATE OF BIRTH:_____

RACE:

____AFRICAN AMERICAN

____ALASKA NATIVE

____AMERICAN INDIAN

____ASIAN

____HISPANIC

____NATIVE HAWAIIAN

____WHITE

____OTHER

ETHNICITY:

____HISPANIC OR LATINO

____NOT HISPANIC OR LATINO

PRIMARY LANGUAGE:_____

Edmonson Aesthetic Facial Surgery, LLC

910 Adams Street, Ste 130

Huntsville , Alabama 35801

256-265-6344

Due to federal privacy guidelines (HIPPA), Edmonson Aesthetic Facial Surgery, LLC is not allowed to divulge medical or financial information to anyone other than the patient (or guardian in the case of a minor) unless explicit authorization is given.

To authorize Edmonson Aesthetic Facial Surgery, LLC to discuss your medical information with someone other than yourself, please fill in below:

I, _____ give Edmonson Aesthetic Facial Surgery, LLC permission to release/discuss personal medical and/or financial information to/with:

NAME OF PERSON	RELATIONSHIP TO PATIENT	PHONE#
NAME OF PERSON	RELATIONSHIP TO PATIENT	PHONE#
NAME OF PERSON	RELATIONSHIP TO PATIENT	PHONE#

_____ _____

SIGNATURE OF PATIENT DATE

FINANCIAL POLICY

Please note that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have with insurer). I directly assign all medical/surgical benefits to Edmonson Aesthetic Facial Surgery and understand that I am financially responsible for all charges not covered by insurances. I hereby authorize Edmonson Aesthetic Facial Surgery to release all information necessary to secure the payment of benefits. In the event of non-payment, either by insurance or myself, I agree to pay all costs of collections, including a reasonable attorney's fee in the event it is necessary to employ an attorney to enforce any provision of this contract. In order to help control the cost of billing, co-payment will be made of all office services at the conclusion of your visit unless other arrangements have been made prior to services being rendered.

_____ _____

Signature of Patient of Legal Representative Date

Authorization to release information

The undersigned authorizes Edmonson Aesthetic Facial Surgery to release any medical or other information about the patient which may be necessary for the treatment, payment or healthcare operations including the proper filing of all insurance claims, review services or receipt of benefits.

_____ _____

Signature of Patient or Legal Representative Date

_____ I acknowledge receipt of the Notice of Privacy Practices posted at the front desk which details how Protected Health Information may be used and disclosed, and how I may access that information.

PAST MEDICAL HISTORY

PLEASE CIRCLE ANY OF THE FOLLOWING MEDICAL CONDITIONS THAT YOU HAVE BEEN TREATED FOR:

ANXIETY

ARTHRITIS

ASHTMA

ATRIAL FIBRILATION (IRREGULAR HEARTBEAT)

BPH

BREAST CANCER

COLON CANCER

COPD

CORONARY ARTERY DISEASE

DEPRESSION

DIABETES

END STAGE RENAL DISEASE

GERD

HEARING LOSS

HEPATITIS

HYPERTENSION (HIGH BLOOD PRESSURE)

HIV/AIDS

HIGH CHOLESTEROL

HYPERTHYROIDISM

HYPOTHYROIDISM

LUNG CANCER

PROSTATE CANCER

STROKE

SEIZURES

OTHER:_____

PAST SURGERIES

BASAL CELL CARCINOMA

MELANOMA

SQUAMOUS CELL CARCINOMA

SKIN CANCER

HEART CONDITIONS

HEART SURGERY

OCULAR HISTORY & SURGERY

ALLERGIC CONJUNCTIVITIS

CATARACT R or L

DETACHED RETINA

DRY EYES

GLAUCOMA R or L

DIABETIC RETINOPATHY

MACULAR DEGENERATION

CONTACT LENSES / GLASSES

OTHER:_____

FAMILY HISTORY PLEASE CIRICLE

BLINDNESS	HEART DISEASE	DIABETES
CANCER	HYPERTENSION	GLAUCOMA
CATARACTS	MACULAR DEGENERATIN	STRABISMUS

SOCIAL HISTORY

DO YOU SMOKE	YES OR NO	PACKS PER DAY_____
DO YOU DRINK	YES OR NO	HOW MUCH_____
LIVING WILL	YES OR NO	
PNEUMONIA VACCINE	YES OR NO	
FLU VACCINE	YES OR NO	

REVIEW OF SYSTEMS (CURRENT CONCERNS) PLEASE CIRCLE

POOR VISION	EYE PAIN	EYE REDNESS	TEARING	WEIGHT LOSS
LOSS OF VISION	JAW PAIN	SCALP TENDERNESS	FEVER	STUFFY NOSE

ALERTS PLEASE CIRCLE

PACEMAKER	YES	NO
ARTIFICIAL HEART VALVE	YES	NO
BLOOD THINNERS	YES	NO
HISTORY OF MRSA	YES	NO
ALLERGY TO IODINE	YES	NO
ALLERGY TO ADHESIVE	YES	NO

LIST ANY MEDICATION ALLERGIES_____

PLEASE LIST ALL CURRENT MEDICATIONS YOU ARE TAKING: _____

_____

_____

_____

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Brenda Edmonson, M.D.

910 Adams Street Ste.130

Huntsville, Al 35801

256-265-6344 Fax 256-265-7965

Authorization for Release/Request of protected Health Information

Patient Name:_____ D.O.B._____

Address_____

Patient's Phone#:_____

I understand that: My right to healthcare treatment is not conditioned on this authorization.

I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.

If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.

Medical records are faxed in cases of medical necessity.

Signature of Patient:_____ Date:_____

FOR OFFICE STAFF USE ONLY:

I authorize Dr. Edmonson to release/obtain medical information to:

Provider or Facility:_____

Address:_____

City/State/Zip:_____

Phone/Fax:_____

Edmonson Aesthetic Facial Surgery, LLC

Patient Portal Information for:

Name_____ **DOB:**_____

Email address_____

****FOR OFFICE USE ONLY****

Portal URL: Edmonson.ema.md (do not use www.)

Username:_____

Password:____Edmonson1_____

A Patient Portal is a secure online website to keep you up to date on your Health Information. The link to initiate access to your Health Information and change your password, it will expire in 48 hours.

We encourage you to visit this website and call if you have any questions

On this page you will be able to review, add and/or edit Pharmacy Information and your Medical History, such as Past Medical History, Medications, Allergies, and some Lab work.

We suggest you to update this information before each visit to save time at your actual visit.

EDMONSON AESTHETIC FACIAL SURGERY, LLC

Patient Portal Terms and Conditions for Use

We are pleased to be able to offer the patient portal service to you. Through this portal, you will be able to request appointments and ask questions. This is a new service we will be offering and so please be patient as we work through any unexpected issues or disruptions in service. We will try to keep these disruptions to a minimum and ask that you bring any issues to our attention.

PLEASE NOTE: The portal is a convenience service; it is not intended to be a substitute for seeing your physician.

In order to access the portal, you must agree to the following terms and conditions.

1. I understand that the portal is NOT to be used for medical emergencies. If I am experiencing a medical emergency, I will call 9-1-1 or go to the nearest emergency room.
2. An adult patient (over 18) may access the portal. Parents and guardians of minor, emancipated, children may access the portal relating to their child. In addition, competent adults may grant third parties the access their portal by following the instructions provided.
3. I understand that it is possible that information on the portal may contain an error or be incomplete or there could be an interruption which causes a question or communication from me or to me, to not be delivered or accessible. If I have a concern or a question or if something is unexpected or confusing, I understand that I should call my doctor's office and not rely on the patient portal information as complete and accurate.
4. I understand that the patient portal may not contain my entire medical record.
5. I understand that my confidential patient information is available through this portal. If I do not log out and close my browser, others may be able to see my information. If I give my user name and password to anyone else, they will be able to access my information.
6. If I believe someone else has access to my user name and password that I have not authorized, I will change my password following the instructions described in the portal.
7. I understand that while Modernising Medicine attempts to ensure that its electronic communications are secure, they may still be subject to interception.
8. I understand that the patient portal is available as a convenience and that Modernising Medicine may terminate access at any time for any reason. I also understand that my participation is entirely voluntary and I can elect to terminate access at any time.
9. I agree that I have no right to copy, modify, change, store, license, assign or exploit the portal software in any manner.
10. The portal and the terms and conditions may be changed periodically. I understand that I should re-read these terms and conditions whenever I access the portal.

If you have any questions or concerns regarding your account please contact as soon as possible.