

**FREDERICK J. MENICK, M.D.**  
Diplomate of the American Board of Plastic Surgery

**Welcome to our Office**

Date: \_\_\_\_\_

**Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Home# \_\_\_\_\_ Work# \_\_\_\_\_ Alt.# \_\_\_\_\_

Social Security# \_\_\_\_\_ D.O.B \_\_\_\_/\_\_\_\_/\_\_\_\_ (Age \_\_\_\_ ) Male or Female

Patient Status: ( )-single ( )- married ( )-separated ( )-divorced ( )-widowed ( )-other

Employer Name \_\_\_\_\_ Phone# \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Reason for Visit? \_\_\_\_\_

How were you referred to Dr. Menick? Yellow Pages \_\_\_\_ Dex online \_\_\_\_ Internet \_\_\_\_ Friend \_\_\_\_

Dr. Menick's website \_\_\_\_ Physician/name \_\_\_\_\_ Other \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ phone # \_\_\_\_\_

E-mail Address: \_\_\_\_\_

*Authorization to release information and assignment of benefits:* I hereby authorize Dr. Menick to release any medical information necessary to process my claim(s) to my insurer, and also authorize payment to be made directly to Frederick J. Menick, M.D.

*Consent to be photographed:* I consent to the photographing of my pre-operative, operative and post-operative condition and the procedures performed. This material may be used for medical, and professional activities, including the INTERNET to provide information and educational materials to medical professionals and the public. I am over 18 years of age.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# Medical History

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Past Medical History/ Review of Systems (do you currently have or have you ever had any of the following)

**Skin**

- atypical moles(nevi)
- pre-cancer lesions
- basal cell carcinoma
- squamous cell carcinoma
- melanoma
- abnormal scarring/keloids
- other \_\_\_\_\_
- NORMAL

**Musculoskeletal**

- artificial joints
- arthritis
- muscle weakness
- fibromyalgia
- other \_\_\_\_\_
- NORMAL

**Neurological**

- stroke
- seizure (epilepsy)
- neuralgia
- numbness/tingling
- other \_\_\_\_\_
- NORMAL

**Cardiovascular**

- high blood pressure
- chest pain
- heart attack
- pacemaker
- artificial heart valve
- other \_\_\_\_\_
- NORMAL

**Respiratory**

- asthma
- emphysema
- cough
- other \_\_\_\_\_
- NORMAL

**Gastrointestinal**

- stomach ulcer
- colitis
- liver problems
- other \_\_\_\_\_
- NORMAL

**Hematologic/Lymphatic**

- anemia
- bleeding problems
- enlarged lymph nodes
- other \_\_\_\_\_
- NORMAL

**Eye/Ear/Nose/Throat**

- glaucoma
- hearing aid
- plastic surgery
- other \_\_\_\_\_
- NORMAL

**Psychiatric**

- depression
- anxiety
- dementia
- other \_\_\_\_\_
- NORMAL

**Endocrine**

- diabetes
- thyroid
- oral steroid use
- other \_\_\_\_\_
- NORMAL

**Infections**

- hepatitis A, B, C
- HIV / AIDS
- tuberculosis / TB
- other \_\_\_\_\_
- NORMAL

**Urologic**

- dialysis
- kidney problems
- venereal disease
- other \_\_\_\_\_
- NORMAL

**Immune**

- lupus
- organ transplant
- cancer chemotherapy
- other \_\_\_\_\_
- NORMAL

**Constitutional**

- weight loss
- fever
- chills
- other \_\_\_\_\_
- NORMAL

- Are you currently pregnant, planning to become pregnant, or nursing?..... Yes No
- Does your Dentist ask you to take Antibiotics before dental work?..... Yes No
- Are you allergic to latex?..... Yes No
- Do you routinely wear sunscreen?..... Yes No
- History of MRSA or VRE? Yes No

Surgeries (skin cancer and all surgeries): \_\_\_\_\_

Hospitalizations/ other Illnesses: \_\_\_\_\_

Medications (Include over the counter meds. and vitamins): \_\_\_\_\_

Allergies (medications, food): \_\_\_\_\_

Social History: Tobacco Use: No \_\_\_ Yes \_\_\_ (age started \_\_\_ amount per day \_\_\_ age quit \_\_\_ currently using \_\_\_)  
Alcohol: No \_\_\_ Yes \_\_\_ (amount per day/week \_\_\_\_\_)

Family History (blood relatives only list relationship to you):

- skin cancer
- other skin problems
- other medical problems
- none known

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**Acknowledgment of Receipt of Privacy Notice**  
Original to be maintained in patient's permanent medical record

I acknowledge that I have received a copy of the office's Notice of Privacy Practices

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name if signed on behalf of the patient

\_\_\_\_\_  
Relationship (parent, legal guardian,  
personal representative, etc. )

**Dr. Frederick J. Menick**  
**Email consent form**

Patient name: \_\_\_\_\_

Patient address: \_\_\_\_\_

Email: \_\_\_\_\_

**1. RISK OF USING EMAIL**

Transmitting patient information by email has a number of risks that patients should consider before using email. These include, but are not limited to, the following:

- a) Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- b) Email senders can accidentally misaddress an email
- c) Copies of email may exist even after they have been deleted by the sender and/or the recipient.
- d) Employers have the right to inspect all emails transmitted through their systems
- e) Email can be altered, intercepted, forwarded, or used without authorization or detection. Email may not be secure. Email can be used to introduce viruses.
- f) Email can be used as evidence in court.

**2. CONDITIONS FOR THE USE OF EMAIL**

Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:

- a) **Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email will be read and responded to within any particular period of time.**
- b) **Email must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via email.**
- c) **All email will usually be printed and filed in the patient's medical record.**
- d) **Office staff may receive and read your messages.**
- e) **Provider will not forward patient identifiable emails outside of our practice without the patient's prior consent except as authorized or required by law.**
- f) **The patient should not use email for communication regarding sensitive medical information. Provider is not liable for breaches of confidentiality caused by the patient or any third party.**

**3. INSTRUCTIONS**

To communicate by email, the patient shall:

- a) Avoid use of his/her employer's computer.
- b) Put the patient's name in the body of the email. Key in the topic (e.g., medical question, billing question) in the subject line.
- c) Inform Provider of the changes in his/her email address. Acknowledge any email received from the Provider.
- d) Take precautions to preserve the confidentiality of email.

**4. PATIENT ACKNOWLEDGEMENT AND AGREEMENT**

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Provider and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with patient by email. If I have any questions I may inquire with Dr. Frederick J. Menick.

Patient signature & Date: \_\_\_\_\_

Witness signature & Date: \_\_\_\_\_

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**FINANCIAL POLICY**

Thank you for choosing Dr. Menick as your plastic surgeon. We sincerely appreciate your trust and the opportunity to serve you. As part of our commitment to service, we make every effort to offer efficient and helpful billing services. It is required that you read, understand, and sign the following financial policy prior to any evaluation or treatment.

**Non-participating plans:**

As a courtesy to you, we will provide you with complete insurance information. Since we do not participate with your plan, the insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please notify us if you have contacted your insurance company and there is additional information that we may provide to help settle the claim. Your insurance company may not reimburse any or all of your claim. Most insurance plans only reimburse a percentage of their allowable charges.

**Usual and Customary Rates:**

Our practice is committed to providing the best care for our patients. You are responsible for payment regardless of any non-participating insurance company's arbitrary determination of usual and customary rates.

**Final considerations:**

Cosmetic surgery is not covered by insurance and is your full responsibility. Surgical fees must be paid in full prior to surgery. There are no exceptions. A \$300.00 deposit is required when scheduling surgery to reserve the surgery time. The deposit as well as one consultation fee will be applied to the total amount of the surgery fee. If you cancel the surgery at least five working days before surgery, the deposit will be refunded. The remainder of the fee must be paid at least five working days before the surgery date by cash, cashiers check, money order, Visa or Master Card. If you pay with an Arizona check, the check must be received at least 2 weeks prior to the surgery date. An out of state check must be received at least 3 weeks before surgery. If these financial requirements are not met, your surgery is subject to cancellation without notice.

If at any time you have questions regarding cost of procedures proposed, you may ask for someone from the financial office to discuss anticipated costs with you.

*Thank you for taking the time to read and understand our financial policy. Please let us know if you have any questions or concerns.*

**I have read, understand and agree to this financial policy.**

\_\_\_\_\_  
**Patient Signature/ Responsible Party**

\_\_\_\_\_  
**Date of Signature**