Dr. Melissa Crosby
PLASTIC SURGERY

Patient Registration Form

Name: ______________________

Date: ____/____/____

PATIENT INFORMATION

Last Name	First		MI	Sex ❑ Male ❑ Female
Height	Weight	Bra Size		
Birth Date / /	Age	SSN - -	Drivers License	
Address	City	State	Zip	
Home Phone # ( ) -	Work # ( ) -	Cell # ( ) -		
Email		Preferred Method of Contact		
Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Domestic Partner				
Spouse's Name		Phone # ( ) -		
Emergency Contact Name		Phone # ( ) -		

INSURANCE INFORMATION

Primary Insurance	Policy #	Type of Network	Group #
Address	City	State	Zip
Insured's Name		Sex ❑ Male ❑ Female	
Insured's Employer		Phone # ( ) -	
Birth Date / /	SSN - -	Relationship to Patient ❑ Self ❑ Spouse ❑ Dependent	
Insurance Address	City	State	Zip
Person Responsible for Payment	Relationship to Patient	Phone # ( ) -	
Address	City	State	Zip

REFERRED BY

Physician	Magazine/Newspaper	Company
Friend	Health Fair/Community Event	Other
If you were refered by a specific person, may we thank them? ____ No ____ Yes		

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

Signature ______________________ Printed Name ______________________ Date ______________

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Date: ____/____/____

PAST MEDICAL HISTORY

- ❑ Abdominal Bleeding
- ❑ Anemia
- ❑ Anxiety Disorder
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Breast Cancer
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chest Pain/Tightness
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ Dizziness/Vertigo
- ❑ Ear Infection
- ❑ Epilepsy/Seizures
- ❑ Facial Pain
- ❑ Fever Blisters
- ❑ Hay Fever/Allergies
- ❑ Headaches/Migraines
- ❑ Heart Attack
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Hives
- ❑ Kidney Stones
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Peripheral Vascular Disease
- ❑ Pheumonia
- ❑ Pulmonary Embolism
- ❑ Sinus Problems
- ❑ Skin Cancer
- ❑ Skin Disease
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Tonsilitis
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Other: ____________________

❑ No to all

ALLERGIES

Are you allergic to any medications? ❑ No ❑ Yes

Medication	Reaction
Medication	Reaction
Medication	Reaction

PREVIOUS SURGERY

Please list any surgeries or hospitalizations you have had in the past ❑ None

Surgery/Illness	Hospital	Year
Surgery/Illness	Hospital	Year
Surgery/Illness	Hospital	Year

CURRENT MEDICATIONS

Please list all current medications ❑ None

Medication	Dosage	Frequency	Reason	Prescribed
Medication	Dosage	Frequency	Reason	Prescribed
Medication	Dosage	Frequency	Reason	Prescribed
Medication	Dosage	Frequency	Reason	Prescribed
Medication	Dosage	Frequency	Reason	Prescribed

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Name: ____________________

Date: ____ / ____ / ____

SYMPTOMS

- ❑ Recent Weight Loss
- ❑ Recent Weight Gain
- ❑ Anxiety Disorder
- ❑ Fevers
- ❑ Chills
- ❑ Rigors
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Chest Pain/Tightness
- ❑ Shortness of Breath
- ❑ Other: ____________________

❑ No to all

GENERAL INFO

Are You Pregnant? ❑ No ❑ Yes: ________ months	Number of pregnancies ______ Vaginal ______ C-Section	Number of children
Use of tobacco products ❑ Never ❑ In the Past ❑ Currently; _____ packs/day	Illicit Drug Use ❑ No ❑ Yes; Type(s): ____________	
Alcohol Consumption ❑ Never ❑ Occasional ❑ Moderate ❑ Heavy ________drinks/week		

FAMILY HISTORY

Family Member	Health Issue	❑ Deceased
Family Member	Health Issue	❑ Deceased
Family Member	Health Issue	❑ Deceased

FINANCIAL RESPONSIBILITY

PLEASE READ CAREFULLY: YOUR INSURANCE CARRIER MIGHT NOT FULLY REIMBURSE YOU FOR HOSPITAL ADMISSION OR SURGICAL PROCEDURES.

I understand that payment in full is expected at the time services are rendered. If prior arrangements have been made, Dr. Melissa Crosby may bill my insurance company for the estimated portion. This is a courtesy to me and I am responsible for the total payment of all charges regardless of insurance coverage.

Since some insurance carriers are unnecessarily delaying payment of claims, I may be called upon for payment if Dr. Melissa Crosby has not received payment. If Dr. Melissa Crosby receives any subsequent payment from my insurance company, then a credit balance will be promptly refunded to me.

I understand that my insurance is a contract between me, my employer and the insurance company. Dr. Melissa Crosby is not a party to that contract and cannot be responsible for negotiating payment.

I hereby authorize my insurance benefits to be paid directly to Dr. Melissa Crosby realizing I am responsible for payment as stated above.

______________________________ ______________

Signature Date

Authorization for the Use and Disclosure of Protected Health Information

I authorize Dr. Melissa A. Crosby, MD, FACS and/or Melissa A. Crosby, MD PLLC to use and disclose my photographs, video, audio recordings, radiologic images, and/or treatment history (PHI) to the public for educational purposes (both in person and online), including presentation at a scientific conference, forum, workshop, or seminar, and/or publication in a printed or electronic scientific journal, textbook, or educational website.

_____ (initial) I also authorize the use of my photos in the Photo Gallery on the Melissa A. Crosby, MD PLLC Website.

My name will not be disclosed; however, I understand that in some circumstances, images/photographs used may be recognizable.

I understand that once my PHI is shared, if the person receiving my PHI is not a health care provider or health plan, my PHI may not be protected by federal privacy laws anymore.

This authorization is optional and I do not have to sign it. If I don't sign, my treatment, payment, and eligibility for benefits will not be affected.

This authorization may be revoked at any time by sending a written request to Melissa A. Crosby, MD PLLC, 16605 Southwest Freeway, Suite 300, Sugar Land Texas 77479. If revoked, no further PHI will be shared, but anything, but anything already shared may stay public.

This authorization has no expiration date.

Signature of Patient or Legally Authorized Rep.: ______________________________

Printed Name: ______________________________ Date: ________________

Legally Authorized Representative's Authority (check all that apply): ____ Parent ____ Guardian

_____ Legal Next of Kin (if patient is deceased) ____ Other (specify): ____________________

Melissa A. Crosby, MD PLLC STAFF USE ONLY

Employee Name/Recipient: ______________________________

A copy of the completed form must be provided to the signing individual. The original must be included in the medical record.

PATIENT AUTHORIZATION FORM DESIGNATING PROVIDER AS AUTHORIZED REPRESENTATIVE FOR BENEFIT APPEAL

(*Print clearly in ink*)

Patient Name: ______________________________ Provider Name: ____________________________

Patient Date of Birth: ____/_____/_______ Provider Address: ______________________________

Relationship to Member: [ ] Self [ ] Spouse [ ] Child

Name of Member/Patient: ____

Member Identification Number: Auth ID: _______________________

This section is to Be Completed by Patient. Parent can sign on behalf of child under 18:

I, ____, do hereby authorize
(patient/parent of minor)

Admin BPS/Dr. Melissa Crosby and affiliates to be my Authorized Representative for the purpose of appealing the denial of benefits for any and all claims submitted by Dr. Melissa Crosby and affiliates on my behalf. This authorization shall remain in effect unless revoked in writing.

____ ________________________

Signature of Patient Date

Preferred Pharmacy Information

Please list your preferred pharmacy for prescription medication to be called in by the office. Please also list any allergies you may have to medications.

Your Name:______________________________ Date of Birth:________________

Name of Pharmacy: ______________________________________

Address:____

____

____

Pharmacy Phone number: ____________________________________

Allergies: ____

____

Cosmetic Interest Questionnaire

Patient Name: ____ Date: _______________

Please complete this questionnaire to help us better understand your aesthetic needs/concerns to personalize a treatment plan.

Please let us know which of the following aesthetic products, treatments, and procedures interest you. Circle all that apply.

Skin Care Advice	Sunscreen Advice	Surgical Procedures
Chemical Peels	Topical Wrinkle Treatment	Radiesse Filler
Botox Treatment	Dysport Treatment	Sculptra
Dermal/Wrinkle Fillers	Clear & Brilliant Treatments	Anti-aging Products
Lip Enhancement	Juvederm Filler	Laser Treatment
Microdermabrasion	Restylane Filler	Skin Rejuvenation
Facials	Kybella Treatment	Microneedling

With respect to facial aesthetics, please circle the areas of concern that you would like to address. Circle all that apply.

Brown Spots/Melasma	Lines Between Brows (Frown)	Face Rejuvenation
Enlarged Pores	Sun Damage of Face & Chest	Aging Hands
Rough Skin Texture	Fine Lines & Wrinkles	Tear Trough
Uneven Skin Tone	Nose to Mouth Lines	Sagging Skin
Freckles	Thin or Small Lips	Temples
Under Eye Area	Double Chin	Corners of the Mouth
Lip Lines	Acne Scars	Mouth to Chin Lines
Crow's Feet	Eyelash Enhancement	Tired Looking Skin

Please take a moment and tell us about your current skincare regimen.

____

____

What aesthetic treatments and/or procedures have you had in the past, if any?

____

Please provide your email address to receive current specials and product information.

____

Prescription History PBM Consent Form

I voluntarily consent to provide Dr. Melissa Crosby LLC access to and use of my prescription medical history through Pharmacy Benefits Managers (PBM) via Surescript and download the prescription information into my electronic medical chart. I understand that my prescription history (which includes but is not limited to prescriptions, labs and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewed by my provider and staff here, and it may include prescriptions dating back for several years.

I acknowledge that Dr. Melissa Crosby LLC may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

I understand that this **Prescription History PBM Consent** will be valid and remain in effect as long as I attend or receive services from Dr. Melissa Crosby LLC, unless revoked by me in writing with such written notice provided to practice.

I certify that I have read this form or it has been read to me.

Date: ______________________________

Print Name:____ **DOB:**____________________

Signature of Patient /Legally Authorized Representative:

____

Relationship to Patient (if Patient not signing):

____

For patients requiring translation or verbal reading of this document, the person reading or translating should document and sign below:

Reader/Translator Signature:______________________________________ **Date:**____________________

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SUGAR LAND, TX 77479

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