Robert J. Knowling, M.D., F.A.C.S

Plastic and Reconstructive Surgery
Certified, American Board of Plastic Surgery

Patient's Name	Martial Status: S M W Div Sep	Date Of Birth	Age	Sex: M F
Street Address	City and State	Zip	Phone	
Email Address	May We Contact You Via Email Regarding Events At Our Office? ❒ Yes ❒ No		Mobile Phone Number	
Patient's Employer	Occupation (Indicate if student)	How Long Employed?	Phone	
Employer's Street Address	City and State	Zip		
Social Security Number	Drivers License Number			
Spouse's Name	Spouse's Date of Birth	Spouse's Work Phone		
Spouse's Occupation	Spouse's Employer	Spouse's Employer's Address		
Reason For Visit				
Who Referred You?	Emergency Contact (Other than spouse)	Emergency Contact's Phone		

If The Patient Is A Minor Or Student

Mother's Name	Street Address, City, State and Zip Code	Home Phone	
Employer's Name	Occupation	How Long Employed?	Business Phone
Employer's Street Address	City and State	Zip	
Father's Name	Street Address, City, State and Zip Code	Home Phone	
Employer's Name	Occupation	How Long Employed?	Business Phone
Employer's Street Address	City and State	Zip	

Insurance Information

Company Name	Company Address	
Name of Policyholder	Date of Birth of Primary Cardholder	Policy Number
Effective Date of Policy	If Group, Company	

In order to control our cost of billing, we request that office visits be paid at the time service is rendered.

I, the undersigned, hereby authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information requested with respect to any physical or mental condition and/or treatment of me. I authorize payment of all medical and surgical benefits directly to Robert J. Knowling, M.D. I realize that all charges incurred by me or my dependents are my financial responsibility and all court fees, attorney's fees or other fees necessary to collect this amount are payable by me.

Patient or Responsible Party ____________________ Date ____________________

V 1.2

Date: ____________

HISTORY & PHYSICAL

Reviewed with patient by: ____________________________

Patient's Name: ____
Last First Middle

Date of Birth: ____/____/______ Age: _____ Male: ☐ Female: ☐

Patient's Status: Single: ☐ Married: ☐ Other: ☐

Family Physican: __________________ Address: ______________________________

Referring M.D.: __________________ Address: ______________________________

Date of last physical: ____/____/______ Any abnormal findings?: Yes: ☐ No: ☐

If yes, please describe: ____

Reason for visit: ____

____

Have you seen another physician for current problem/concern? Yes: ☐ No: ☐

If yes, who? ____

Social History:

Do you smoke? Yes: ☐ No: ☐ Packs per day: _______

Do you drink alcoholic beverages? Yes: ☐ No: ☐ Drinks per day: _______

Are you allergic to any medications? Yes: ☐ No: ☐ List any medications you are allergic to and reaction:

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Pharmacy name: ____________________ Telephone Number: ____________________

Do you take Aspirin or anti-inflammatory medications? Yes: ☐ No: ☐

List all medications you are currently taking (including herbs, over the counter medications & vitamins):

Medication	Dosage	Times/Day	Medication	Dosage	Times/Day

Previous Operations or Admission to Hospital

Date:	Type:	Complications: (Surgery or Anesthesia)

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU HAD RECENTLY? (PLEASE CIRCLE)

Eye/Ear Problems

Glaucoma	Yes	No
Cataracts	Yes	No
Glasses/Contacts	Yes	No
Hearing Aids	Yes	No

Respiratory Problems

Asthma	Yes	No
Wheezing	Yes	No
Shortness Of Breath	Yes	No
Pain With Breathing	Yes	No
Coughing Up Blood	Yes	No

Genital Problems

Sores	Yes	No
Infections	Yes	No
Herpes	Yes	No
AIDS	Yes	No
AIDS Related Disease	Yes	No

Metabolic Problems

Diabetes	Yes	No

How long diagnosed:____________

Controlled by: Med ☐ Diet ☐

Low Blood Sugar	Yes	No

Nose/Throat Neck

Hoarseness	Yes	No
Voice Changes	Yes	No
Nose Bleed	Yes	No
Thyroid	Yes	No

Gastrointestinal Problems

Stomach Ulcers	Yes	No
Gallbladder Trouble	Yes	No
Pancreatitis	Yes	No
Colitis	Yes	No
Blood In Stool	Yes	No
Hiatal Hernia	Yes	No
Liver Trouble	Yes	No

Neurological Problems

Headaches	Yes	No
Fainting/Blackouts	Yes	No
Seizures/Epilepsy	Yes	No
Strokes	Yes	No
Paralysis	Yes	No

Bleeding Disorder

Anemia	Yes	No
Bleeding Problems	Yes	No

Cardiovascular

Chest Pain	Yes	No
Irregular Heartbeats	Yes	No
Low Blood Pressure	Yes	No
High Blood Pressure	Yes	No

Urinary Problems

Bloody Urine	Yes	No
Frequent Urine	Yes	No
Night Time Urination	Yes	No
Trouble Starting	Yes	No
Trouble Stopping	Yes	No
Pain With Urination	Yes	No

Skin Problems

Infections	Yes	No
Psoriasis	Yes	No
Skin Cancer	Yes	No

Female Medical History

Are You Pregnant? Yes No

Birth Control Method: ____________

Last Menstrual Period: ____________

Number Of Children: ____________

Number Of Term Pregnancies: ______

Did You Breastfeed? Yes No

Height:_______ Weight:_______ B/P:_______ Heart Rate:______ Bra Size:_____

FAMILY HISTORY: List any family history of medical problems or illness. Include heart, lung, blood pressure, diabetes, asthma, cancer, stroke, etc.

Mother: ______________________________

Father: ______________________________

Maternal Grandmother: ______________________

Maternal Grandfather: ______________________

Sister: ______________________________

Brother: ______________________________

Paternal Grandmother: ______________________

Paternal Grandfather: ______________________

PHYSICAL EXAMINATION (Physician Only)

General:

Psychological Status:

Heart:

Lungs:

Other Findings:

____

Patients' Signature/Parent, if minor Date

____

Physician's Signature Date

ROBERT J. KNOWLING, M.D., P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Robert J. Knowling, M.D., P.C. to use and disclose protected health information (PH) about me to carry out treatment, payment and healthcare operations (TPO). (The Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Robert J. Knowling, M.D., P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Robert J. Knowling, M.D., P.C. Privacy Official at 4011 Balmoral Drive Huntsville, AL 35801.

With this consent, Robert J. Knowling, M.D., P.C. may call my home or other alternative location and leave a message or voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminds, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Robert J. Knowling, M.D., P.C. may mail to my home or other alternate locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential .

With this consent, Robert J. Knowling, M.D., P.C. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Robert J. Knowling, M.D., P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Robert J. Knowling, M.D., P.C. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already my disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Robert J. Knowling, M.D., P.C. may decline to provide treatment to me

______________________________	______________________________
Signature of Patient or Legal Guardian	Print Name of Patient or Legal Guardian
______________________________	______________________________
Patient's Name	Witness

Please list family, friends, or any person we may release medical information to other than your referring doctor. Please list full names of the person/people and relationship so we may assist you in a timely manner.

Names	Relationship:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, ____, hereby request that Robert J.

Knowling, M.D., provide to ____
(Doctor's Name and Complete Address)

____

any information including diagnosis, treatment, prognosis, and records, as well as other

data pertinent to his treatment of me from _________ to __________.
(Date) (Date)

Signed: _________________________________

Witness: ________________________________

Date: __________________________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, ____, hereby request that

____
(Doctor's Name and Complete Address)

provide to Robert J. Knowling, M.D., any information, including diagnosis, treatment,

prognosis, and records, as well as other data pertinent to his treatment of me

from _________ to __________.
(Date) (Date)

Pre and post-operative photographs, as pertain to the treatment in question, may be

copied and released to Dr. Knowling as well: _____Yes ___No

Signed: __________________________________

Witness: _________________________________

Date: ___________________________________

Smoking, second-hand smoke exposure, nicotine products (patch, gum, nasal spray)

Patients, who are currently smoking, use tobacco products, or nicotine products (patch, gum, or nasal spray) are at a greater risk for significant surgical complications. Individuals exposed to second-hand smoke are also at potential risk for similar complications attributable to this exposure. Additionally, smoking may have a significant negative effect on anesthesia and recovery from anesthesia. Individuals who are not exposed to tobacco smoke or nicotine-containing products have a significantly lower risk of this type of complication. I understand that if my history is that of having smoked and/or continuing to smoke, the degree of improvement achievable with any procedure and the extent to which the procedure may be undertaken may be affected. Specifically, a more conservative approach with less expected change may, at the surgeons option, be undertaken in order to lessen the risks of the procedure (some of which are afforded by ongoing smoking and/or a history of smoking). The surgeon will decide if the procedure falls within the scope of acceptable risk, taking the patients medical/surgical history and smoking history (both prior and current) into account.

_______I am a non-smoker and do not use nicotine products. I understand the risks associated with exposure to second-hand smoke. I agree to abstinence from smoking, use of tobacco or nicotine products and second hand smoke exposure for a four week period pre-operatively and four week period post-operatively

_______I am a smoker or use tobacco/nicotine products. I understand the risk of surgical complications related to prior and/or ongoing smoking or use of nicotine products. I understand the potential limitation on the ultimate result/degree of improvement afforded by my smoking history and/or ongoing smoking. I agree to abstinence from smoking, use of tobacco or nicotine products and second hand smoke exposure for a four week period pre-operatively and a four week period post-operatively.

Patient signature: _________________________________ Date:________________

Witness: ____