J. SMYTHE RICH, III, M.D.
Facial Plastic & Reconstructive Surgery

PATIENT INFORMATION

******Please submit your Drivers License and Insurance Card with this form******

Demographics:

Patient Name:_____**Age:**_____**Date:**_____

Date of Birth:_____ **Gender: Male / Female** **SSN:**_____

Primary Care Physician: _____ ***Phone:***_____

Referring Physician: _____ ***Phone:***_____

Marital Status:_____ **Ethnicity:**_____ **Race:**_____

Patient Address:_____**City:**_____**State:**_____**Zip:**_____

Home Phone:_____ **Work Phone:**_____

***Cell Phone:**_____ **Carrier (for Appt. Reminder Texts)**_____

***Email Address:**_____

Emergency Contact:_____**Relationship:**_____**Phone:**_____

Consent for Communication:

Method	*Leave VoiceMail*	*Leave Message with Person*	*Preferred (choose 1)*
Work Phone	☐	☐	☐
Cell Phone	☐	☐	☐
Home Phone	☐	☐	☐

How did you hear about us?

[ ] Your Doctor _____ **[ ] Friend**_____

[ ] Advertisement_____ **[ ] Internet**_____

[ ] Other (Please Specify)_____

***By providing your email and/or cell phone number, you are consenting to receive your appointment reminders via these means, and occasional practice-specific patient information from our office (no more than 1-2 emails per month other than appointment reminders)**

******Please submit your Drivers License and Insurance Card with this form******

1711 Richland Street Columbia, South Carolina 29201
P. 803.799.3223 (FACE) F. 803.933.9460 www.scfaces.com

CERTIFIED
American Board of Facial Plastic and Reconstructive Surgery | American Board of Otolaryngology/Head and Neck Surgery
Practice limited to reconstructive and cosmetic facial plastic surgery, functional and cosmetic nasal/sinus surgery

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Medical History

Name:_____Date of Birth:_____ Date:Wed 6/30/2021

Reason for visit?_____

Who is your family doctor?_____Phone Number_____

When was your last physical examination?_____

Pharmacy: _____ Address or Phone:_____

Have you had any of these procedures performed?

[ ] Filler [ ] Botox [ ] Rhinoplasty [ ] Chin [ ] Face or Neck Lift [ ] Eyelids [ ] Removal of cysts, warts, moles, etc

[ ] Chemical Peel [ ] Resurfacing [ ] Scar Revision [ ] Ears Pinning [ ] Liposuction [ ] Other_____

Check any of the following that you have experienced:

[ ] Asthma	[ ] Arthritis	[ ] Venereal Disease	[ ] Other Blood Problems
[ ] Hay Fever	[ ] Arthritis Therapy	[ ] AIDS	[ ] Alcohol Abuse Therapy
[ ] Nasal Allergies	[ ] Steroid Therapy	[ ] Frequent Headache	[ ] Bouts of Depression
[ ] Vision Problems	[ ] Poor Circulation	[ ] Excess Scarring	[ ] Bouts of Unhappiness
[ ] Thyroid Therapy	[ ] Kidney Trouble	[ ] Dizziness	[ ] Nervous Breakdown
[ ] Frequent Chest Pain	[ ] Bladder Trouble	[ ] Convulsions	[ ] Psychiatric Therapy
[ ] Lung Trouble	[ ] Skin Infection	[ ] Paralysis	[ ] Stomach Ulcers
[ ] Heart Trouble	[ ] Skin Irritation	[ ] Hormone Therapy	[ ] Other Stomach Trouble
[ ] High Blood Pressure	[ ] Rashes	[ ] Anemia	[ ] Liver Trouble
[ ] Diabetes	[ ] Fever Blisters	[ ] Profuse Bleeding	[ ] Gall Bladder Trouble
[ ] Yellow Jaundice	[ ] Genital Herpes	[ ] Excess Bruising	[ ] Drug Abuse Therapy

☐Yes ☐No Are you currently pregnant or breastfeeding?

☐Yes ☐No Are you now taking **any** drugs or medications? What and how often:_____

_____

☐Yes ☐No Are you allergic to **any** medications, creams, tape, make-up, etc?_____

☐Yes ☐No Do you smoke Cigarettes? How many a day?_____

☐Yes ☐No Do you drink more than 6 cups of coffee a day?

☐Yes ☐No Do you usually drink two or more alcoholic drinks a day?

☐Yes ☐No Do you have any other medical problems that have not been covered?_____

_____

☐Yes Do you accept the fact that every medical and surgical treatment is associated with risks? ☐No

☐Yes Do you give consent and authorize the recommended diagnostic, medical, surgical, anesthetic, and other diagnostic services that the clinic deems beneficial while you are under their care? ☐No

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FINANCIAL POLICY, COMMUNICATIONS,& HIPAA CONSENT

We will file *medically necessary* services to your *in-network* insurance carrier as a courtesy. It is your responsibility to ensure that your insurance carrier processes your claim in a timely manner and/or to resolve any discrepancies concerning payment with your insurance carrier. All charges must be paid in full within 60 days of occurance. Any balance remaining after 60 days may be subject to collection activity and associated collection fees up to 50% of the overdue balance *plus* up to $25 in adminisrative fees. Missed appointment and excesssive cancellations or re-scheduled appointments will result in a $50 fee for each appointment, and a $150 fee for procedures. All returned checks will be subject to a $30 Returned Check fee. Payment is accepted in the form of: Cash, Check, Visa, MasterCard, Discover, and/or Gift Certificates issued by our office. ***Payment is expected in full at the time of service.***

Insurance Information: *(Insurance Card Required-Please Provide With This Paperwork)*

Insurance Carrier:_____ID#:_____ Group#:_____

Insured: ☐ Self ☐ Other: Name:_____ Relationship to Patient:_____

Policyholder SSN:_____ Policyholder DOB:_____ Sex: ☐ Male ☐ Female

Policyholder Address:_____ Phone:_____

Employer:_____ ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Military ☐ Student

Photo Release:

Consent to the Release of Photos for the Purpose of:

☐ Medical Use/Study and/or Instruction for other Medical Professionals
☐ In-Office Use for Before and After or other examples of conditions/treatment
☐ Internet (Website/Email/Social Media for Information and/or Advertising)
☐ Print Advertising for Outside Distribution
☐ Limitations/Considerations:_____

Protected Health Information(PHI):

PHI will not be released to any party except as authorized by law, or with written or verbal consent from the patient. I authorize the release of any medical information by Smythe Rich, MD, PA as necessary:

- For the purposes of diagnosis and treatment of any medical condition.
- To obtain payment for services rendered by J. Smythe Rich, MD, PA or members of his staff.
- To submit medical claims and request payment of medical benefits to Smythe Rich, MD, PA, for services described on the claim form.
- To the following individual(s):

1. Name:_____Date of Birth:_____ Relationship:_____
2. Name:_____Date of Birth:_____ Relationship:_____
3. Name:_____Date of Birth:_____ Relationship:_____

I have been offered and read the privacy policy and financial policy and agree to the terms herein. This notice has been issued and is effective on the date signed. I understand that this authorization or a photo copy shall be valid.

_____ _____
Signature Date

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