STEWART & THAXTON PLLC
ANDY STEWART, MD ■ JEFF THAXTON, MD
4415 MacCorkle Avenue, SE, Charleston, WV 25304 · p: 304-925-8949 · f: 304-925-8953
Plastic Surgery - Reconstructive Surgery - Aesthetics

PATIENT MEDICAL HISTORY

Patient Name: _____ **Date:** _____

Height: _____ **Weight:** _____ **Age:** _____

☐ Yes ☐ No Do you smoke? Packs per day: _____ Number of years: _____
☐ Yes ☐ No Do you use tobacco products? Packs/cans per day: _____ Number of years: _____
☐ Yes ☐ No Have you ever smoked or used tobacco products in the past?
Packs per day: _____ Number of years: _____ When did you quit? _____
☐ Yes ☐ No Do you consume alcohol? # of drinks per week _____
☐ Yes ☐ No Do you take or have you taken recreational drugs?

☐ Yes ☐ No Are you allergic to latex (rubber) products? Tapes? _____
☐ Yes ☐ No Have you experienced chest pain or tightness?
☐ Yes ☐ No Do you have a heart condition? Explain: _____
☐ Yes ☐ No Do you have hypertension (high blood pressure)?
☐ Yes ☐ No Do you have high cholesterol/triglyderides?
☐ Yes ☐ No Do you or have you experienced shortness of breath? Explain: _____
☐ Yes ☐ No Do you have (please circle): asthma bronchitis COPD emphysema other breathing problem
Explain: _____
☐ Yes ☐ No Do you have a history of strokes or seizures?
☐ Yes ☐ No Do you have diabetes?
Yes ☐ No ☐ Insulin dependent?
☐ Yes ☐ No Have you had (please circle): hepatitis liver disease jaundice Explain: _____
☐ Yes ☐ No Do you have a thyroid condition? (Please circle one.) Hypo Hyper Explain: _____
☐ Yes ☐ No Do you have or have you had kidney disease?
☐ Yes ☐ No Do you have or have you had ulcers or other stomach disorders? Explain: _____
☐ Yes ☐ No Do you have a hiatal hernia or any other hernias? Explain: _____
☐ Yes ☐ No Do you have reflux or frequent heartburn?
☐ Yes ☐ No Do you have back or neck pain? Explain: _____
☐ Yes ☐ No Do you have numbness, weakness, or paralysis of your extremities? Explain: _____
☐ Yes ☐ No Do you have any muscle or nerve disease? Explain: _____
☐ Yes ☐ No Do you have or have you ever had any bleeding problems? Explain: _____
☐ Yes ☐ No Have you ever had a blood transfusion? Explain: _____
☐ Yes ☐ No Do you use a CPAP or do you have sleep apnea?
☐ Yes ☐ No Have you ever been tested for sleep apnea? Explain: _____
☐ Yes ☐ No Have you ever had congestive heart failure? Explain: _____
☐ Yes ☐ No Do you have anxiety?
☐ Yes ☐ No Do you have a depression disorder? Explain: _____
☐ Yes ☐ No Have you had breast cancer?

PATIENT MEDICAL HISTORY (cont.)

☐ Yes ☐ No Have you had any other types of cancer? Please list: _____

☐ Yes ☐ No Have you had any skin cancers? Please list type(s) and area(s): _____

☐ Yes ☐ No Have you ever had any problems with anesthesia? Please list: _____

☐ Yes ☐ No Have you had any other illness not indicated above? Please list: _____

_____

☐ Yes ☐ No Is there anything else that would be valuable for us to know? Please list: _____

_____

Drug Allergy	**What reaction did you have to this medication?**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medication	**Dose**	**Frequency (How many times/day)**	**Reason for taking this medication**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Surgeries	**Date of surgery**	**Name of Surgeon**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY MEDICAL HISTORY Mark any diseases that have occurred in your immediate family. (Parents, grandparents, siblings.)

☐ Yes ☐ No Diabetes: who has it? _____

☐ Yes ☐ No High blood pressure: who has it? _____

☐ Yes ☐ No Heart disease: who has it? _____

☐ Yes ☐ No Cancer: who has it and what type? _____

☐ Yes ☐ No Thyroid disease: who has it? _____

☐ Yes ☐ No Lung disease: who has it? _____

☐ Yes ☐ No Kidney disease: who has it? _____

☐ Yes ☐ No Problems with anesthesia? Who and what type of problem? _____

Any other medical issue not listed above: Who and what? _____

I hereby certify that the forgoing information is correct. If there are any changes in my medical history I will notify Stewart & Thaxton.

Patient Signature: _____ **Date:** _____

Patient Printed Name: _____

STEWART & THAXTON PLLC

ANDY STEWART, MD ■ JEFF THAXTON, MD

Patient Information

First Name:	**Last Name:**	**MI:**	**Select Primary # Below ↓**
Address:			**Home Ph:** ☐
City	**State:**	**Zip:**	**Work Ph:** ☐
DOB:	**Age:**	**Sex:**	**Cell Ph:** ☐
SSN:	**Marital Status:**		**Spouse Name:**
Race:	**Ethnicity:**		**Email:**
Occupation/Job:		**Employer:**	
Primary Care Physician:	**PCP Ph:**		**If Retired, Date:**

***Our Physicians would love to keep you updated on special offers/events for Botox, Juvederm, Latisse, and Obagi via email or US mail.**

Please contact me via ☐ Email ☐ Mail ☐ I do not wish to be contacted about promotions or events.

Emergency Contact

First Name:	**Last Name:**	**Relationship to Patient:**
Home Ph:	**Cell Ph:**	**Work Ph:**

Insurance Information:

Primary Insurance Name:		
Primary Insured's Name:	**Insured Social Security #:**	**Insured DOB:**
Secondary Insurance Name:		
Secondary Insured Name:	**Secondary Social Security:**	**Secondary DOB:**

Parent/Legal Guardian (If Patient is a Minor)

Mother's Name:	**DOB:**	**Home Ph:**
Employer:	**Work Ph:**	**Cell Ph:**
Father's Name:	**DOB:**	**Home Ph:**
Employer:	**Work Ph:**	**Cell Ph:**

Other Information

Referred By:	**Reason for Visit:**	
Workers Compensation: Yes ☐ No ☐	**Auto Accident:** Yes ☐ o ☐	**Other:**
Does this involve litigation: Yes ☐ No ☐	**If yes, please explain:**	

Patient Signature **Date:**

Witness Signature: **Date:**

Members AMERICAN SOCIETY OF PLASTIC SURGEONS

4415 MacCorkle Avenue, SE Charleston, WV 25304 Phone: (304) 925-8949 Fax: (304) 925-8953

W. Andrew Stewart, MD
Jeffrey N. Thaxton, MD
Mountain State Plastic Surgeons

Plastic and Aesthetic Surgery

HIPAA Notice of Privacy Practices

W. Andrew Stewart, MD, FACS and Jeffrey N. Thaxton, MD
4415 MacCorkle Avenue, SE, Charleston, WV 25304 phone: 304-925-8949

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected heath information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physicians, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be proceed to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

We may use or disclose, as needed, your protected health information in order to support the business

Healthcare Operations: s activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required By Law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Worker's Compensation, Inmates, Required Uses and Disclosures, Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

I, _____ authorize Stewart and Thaxton, PLLC to speak to _____ regarding my appointments and care provided.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You're Rights

Following is a statement of your rights with respect to your protected health information.

W. Andrew Stewart, MD
Jeffrey N. Thaxton, MD
Mountain State Plastic Surgeons

Plastic and Aesthetic Surgery

You have the right to inspect and copy your protected health information. Under the federal law, however, you may not inspect or copy the following records, psychotherapy notes, information compiled in reasonable anticipation of, or us in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to who you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and became effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Print Name: Signature: Date:

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