

Dear \_\_\_\_\_:

**We have scheduled an appointment for you to see**

\_\_\_\_\_ **on** \_\_\_\_\_  
**at** \_\_\_\_\_ **o'clock.** Please follow instructions following  
boxes:

If you are coming to see the doctor for the first time,  
please enter Suite 1421 and take the stairs to our consultation  
offices. This appointment is for a consult only. ***Surgery will be  
scheduled, if appropriate, at a later date.***

**Please note that if you have any difficulty climbing  
stairs, we will gladly see you in our downstairs office.**

If your appointment is with a nurse, please enter at Suite 1421  
and check in at our downstairs office.

If you are coming to see our Skin Health Professionals  
or Laser Specialists, please enter at Suite 1532, the  
glass door to the right of our main entrance.

**Our office is on the east side of the Park Plaza Office Complex  
facing Gallatin Street.**

Please bring your completed information sheets to your first  
appointment. It is important for you to fill out your medical  
history forms completely (notice there is a front and back side),  
including all medications that you are currently taking. **Please  
bring your current meds with you to your first appointment.** You  
should allow between one and two hours for this appointment.  
We make every effort to keep appointments timely.

Make sure to bring your insurance card(s) and driver's license  
to your appointment. We will need to make a copy of these for  
your file. In compliance with rules put forth by the FTC, if you do  
not have a photo ID we will need to receive two other forms of identity,  
such as a social security card, school or work ID, utility bill, birth certifi-  
cate, etc., that provides personal identification. We **DO** participate with  
BC/BS of Alabama, Medicare, Premier, PHCS, Namci, Aetna, UHC,  
Tricare and several other insurance plans. If we participate with your  
insurance, we will ask that you pay your co-pay on the day of your visit.  
If we do not participate with your insurance, we will ask that you pay for  
your visit. We will gladly file an insurance claim for your reimbursement.

**Please note we are not participating providers for Tricare Prime.**

If you are coming for a cosmetic consultation with the doctor,  
please be prepared to pay the \$50 consultation charge.

If you are coming for a Skin Health Consultation, please come  
without makeup or be prepared to remove it once you are here.

You will receive a skin health analysis at which time a home care  
and office treatment plan will be recommended.

We welcome any questions you may have prior to your appointment.  
The Skin Health and Laser Center's direct line is 256-532-2383. Our insurance  
line is 256-532-2382 ext. 501. Otherwise, please call our main number  
which is 256-536-4448 or 800-949-4448.

Thank you for scheduling your appointment with us. We look forward to  
meeting with you.

Sincerely,



# Dunagan Yates & Alison Plastic Surgery Center

303 Williams Av. SW Suite 1421

Huntsville, AL 35801

256-536-4448 • 800-949-4448 • website: [www.dyaplasticsurgery.com](http://www.dyaplasticsurgery.com)

## Consent for Use of Email for Commercial Purposes

We are very pleased to have you as a part of our practice. Some of the things we offer our patients we tell you about through email, our website ([www.dyaplasticsurgery.com](http://www.dyaplasticsurgery.com)) and our Facebook page (log in to FaceBook and search for Dunagan Yates & Alison Skin Health and Laser Center, or just click the link from the homepage of our website).

We send email notifications of seminars we are hosting, open house/appreciation events in our Skin Health and Laser Center, and special pricing on products and services that are available throughout the year. We may also use your email address to remind you of an appointment if we are unable to reach you by phone. We will be happy put you on our email list, if you would like to receive this information through your email account. To receive information this way please provide your full name, date of birth and current email address:

<b>Full Name</b>	<b>DOB</b>	<b>Email Address</b>

There are certain email rules that all businesses must follow to protect recipients from unwanted emails. Since not everyone knows about these we wanted to make you aware.

All commercial email documents must give the recipient the opportunity to opt out of receiving further emails from the source. If you ever “opt out” you will be removed from the list and you will not receive any further emails from us.

Emails are considered permission marketing or education, and these rules are meant to protect you from unwanted email “spam”. If you have opted out and would like to begin receiving emails from us again you may provide us with a written statement that you want to begin receiving emails from us and the email address to which you want them sent, along with your name, and date of birth. To avoid having emails go to your spam file you can go to your email settings to “always allow” emails from Dunagan Yates and Alison, if you wish to receive them.

The information that is sent in these emails is also uploaded to our website and to Facebook, so please make it a habit to check us out on our website, and to like us on Facebook.

If you change your email address please let us know the next time you are in the office so we can keep your information updated. Thank you for the trust you place in us.

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_ **Witness** \_\_\_\_\_

# Patient Information Questionnaire

303 Williams Ave., Suite 1421 • Huntsville, AL 35801 • 256-536-4448

Deason C Dunagan, M.D., F.A.C.S. • Michael D Yates, M.D., F.A.C.S. • William E. Alison, Jr., M.D., F.A.C.S.

## A. Patient Information

Date \_\_\_\_\_

Patient Name \_\_\_\_\_  
First Middle Last

Patient Address \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ DOB \_\_\_\_\_  
 Single  Married  Other  Male  Female

Permanent Address (if different from above) \_\_\_\_\_

Please indicate phone numbers at which we may leave message by circling yes or no:

Home # \_\_\_\_\_ YES/NO Work # \_\_\_\_\_ Ext \_\_\_\_\_ YES/NO

Mobile # \_\_\_\_\_ YES/NO Pager# \_\_\_\_\_ YES/NO

Email Address \_\_\_\_\_ Please include this if you want to receive email info from us.

Occupation \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Referring Physician \_\_\_\_\_ Reason for today's visit \_\_\_\_\_

Emergency Contact Information: Name \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone #s \_\_\_\_\_

## B. Insured Party Information (complete section B if the responsible/insured party differs from the patient)

Resp/Insured Party \_\_\_\_\_  
First Middle Last

If patient is a child give name, phone and address of both parents \_\_\_\_\_

If divorced, give name of custodial parent \_\_\_\_\_

Relationship to patient:  Spouse  Father  Mother  Other

Insured's Address \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Insured's DOB \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

## C. Insurance Company Information

Be sure to bring your insurance cards to this appointment. If insurance information is not supplied you will be billed for your appointment.

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

## D. Accident/Injury

Is this visit for  Work injury?  Auto accident?  Other injury?

Date of accident/injury \_\_\_\_\_ Responsible Party \_\_\_\_\_

Workman's Comp: Employer \_\_\_\_\_ Date of Employment \_\_\_\_\_

Address \_\_\_\_\_

Contact Person \_\_\_\_\_ Phone# \_\_\_\_\_

Workman's Comp Carrier \_\_\_\_\_ Policy# \_\_\_\_\_

Signature of Employer's Representative \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date: \_\_\_\_\_

Who referred you to our clinic? \_\_\_\_\_

Reason you are here today? \_\_\_\_\_

**MEDICAL HISTORY**

**MEDICAL ILLNESSES:**

Type	Doctor who treats you for this
a. _____	_____
b. _____	_____
c. _____	_____
d. _____	_____
e. _____	_____
f. _____	_____

**SURGERY (Operations):**

Type	Date	Complications or Difficulties
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____
d. _____	_____	_____
e. _____	_____	_____
f. _____	_____	_____

**ADMISSIONS TO HOSPITAL (Other than surgeries):**

Reason	Date	Complications or Difficulties
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____
d. _____	_____	_____
e. _____	_____	_____
f. _____	_____	_____

**MEDICATIONS:** List all medications/prescriptions and over the counter drugs (herbs, vitamins, cold medicine, etc.) and the reason you are taking them.

Name of Medication	Reason for Taking	Dosage	How Often Taken	Prescribing Physician
a. _____	_____	_____	_____	_____
b. _____	_____	_____	_____	_____
c. _____	_____	_____	_____	_____
d. _____	_____	_____	_____	_____
e. _____	_____	_____	_____	_____
f. _____	_____	_____	_____	_____
g. _____	_____	_____	_____	_____
h. _____	_____	_____	_____	_____
i. _____	_____	_____	_____	_____
j. _____	_____	_____	_____	_____

Name of Pharmacy \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date: \_\_\_\_\_

Do you take aspirin, BC powders, Goody powders, Advil, Motrin or other similar over-the-counter pain medications? YES/NO

If yes, please list: \_\_\_\_\_

Do you use drugs socially or have a history of drug abuse? YES/NO If yes, please explain: \_\_\_\_\_

Are you under a pain contract with any physicians? YES/NO If yes, please list name of physician and contact information: \_\_\_\_\_

ALLERGIES: Please list any medications that you have had an allergic or adverse reaction to:

Name of Medication	Severity of Reaction
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- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_
- f. \_\_\_\_\_

Are you allergic to any local anesthetics? YES/NO If yes, please explain: \_\_\_\_\_

Do you have a latex sensitivity or allergy (itching, redness, swelling, rash, breathing problems, or anaphylaxis)? YES/NO If yes,

Please explain: \_\_\_\_\_

Are you allergic to paper tape or bandaids? YES/NO If yes, please explain \_\_\_\_\_

If you have this information please list:

Date of last:

- |                      |             |               |
|----------------------|-------------|---------------|
| a. Chest X-ray _____ | Where _____ | Results _____ |
| b. EKG _____         | Where _____ | Results _____ |
| c. Mammogram _____   | Where _____ | Results _____ |

Name of Family Doctor \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

Results of physical exam \_\_\_\_\_

WOMEN: You cannot have surgery if you are pregnant (surgery, anesthesia and some medications can cause birth defects).

- a. Are you pregnant?                      Yes      No
- b. Last monthly period \_\_\_\_\_
- c. Birth control method \_\_\_\_\_ (some medications can decrease the effectiveness of birth control pill for a month)
- d. Number of pregnancies \_\_\_\_\_
- e. Number of children you delivered \_\_\_\_\_
- f. Problems or complications during pregnancy, labor or delivery? \_\_\_\_\_

**Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FAMILY HISTORY**

Family History: List medical problems such as heart disease, high blood pressure, cancer, TB, Diabetes, blood clots, melanoma, etc. if it applies to your family members listed below:

Deceased (D)/Living (L)      Cause of Death      Age at Death      Medical Problems

Father \_\_\_\_\_

Mother \_\_\_\_\_

Sisters \_\_\_\_\_

Brothers \_\_\_\_\_

Maternal Grandparents \_\_\_\_\_

Paternal Grandparents \_\_\_\_\_

Do you have a personal or family difficulties with local or general anesthesia? **YES/NO**

If yes, please explain: \_\_\_\_\_

Is there a personal or family history of:

Malignant Hyperthermia: **YES/NO**

Muscle Disorder: **YES/NO**

Neuromuscular Disorder: **YES/NO**

High Temperature Following Exercise: **YES/NO**

Personal History of Muscle Spasm: **YES/NO**

Dark or Chocolate Colored Urine: **YES/NO**

Unanticipated Fever Immediately Following anesthesia or serious exercise: **YES/NO**

If you answered **YES** to any of the above please explain: \_\_\_\_\_

**SOCIAL HISTORY**

Do you smoke or use other tobacco products? **YES/NO** If yes, what type and how much? \_\_\_\_\_

Do you drink alcohol? **YES/NO** If yes how much and how often? \_\_\_\_\_

**REVIEW OF SYSTEMS**

If you currently have or have had any of the following diseases in the past, please indicate by drawing a circle around the problem and **explain in detail**. If you do not have or have not had a problem please circle **“NO.”**

1. Eyes (contacts, corrective lenses, lens implants, cataract surgery, cataracts, blurred vision, dryness, glaucoma, etc)? \_\_\_\_\_ **NO**

2. Ears, Nose, Mouth, and Throat (allergies, sinus trouble, hay fever, deviated septum, decreased hearing, jaw problems, neck stiffness, sleep apnea, vocal cords problems, etc.)? \_\_\_\_\_ **NO**

3. Heart and Blood vessels (heart disease, blocked heart vessels, chest pain, angina, irregular heart beat, congestive heart failure, shortness of breath when lying flat or with mild exercise, ankle swelling, heart valve disease, heart murmurs, rheumatic heart disease, congenital heart defect, heart surgery, heart bypass, heart valve surgery, pacemaker, high blood pressure, etc.)? \_\_\_\_\_ **NO**

4. Lungs (emphysema, bronchitis, asthma, tuberculosis, persistent cough, productive cough, etc.)? \_\_\_\_\_ **NO**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date: \_\_\_\_\_

5. Digestive System (hiatal hernia, persistent diarrhea, recent weight loss, stomach ulcer or hyperacidity, indigestion/reflux, recent nausea and vomiting, etc.)? \_\_\_\_\_ NO

6. Reproductive System (sexually transmitted disease, enlarged prostate, fibroid tumors, ovarian cysts, etc.)? \_\_\_\_\_ NO

7. Kidneys/Bladder (persistent infection, stones, kidney failure, dialysis, etc.)? \_\_\_\_\_ NO

8. Musculoskeletal (arthritis, painful swollen joints, neck problems, back problems, leg discomfort, tingling or numbness of extremities, etc.)? \_\_\_\_\_ NO

9. Skin (basal cell cancer, squamous cell cancer, melanoma, psoriasis, other skin disease, etc.)? \_\_\_\_\_ NO

10. Head (stroke, TIA, epilepsy, fainting spells, headaches, seizures, etc.)? \_\_\_\_\_ NO

11. Psychiatric (mental illness)? \_\_\_\_\_ NO

12. Endocrine (thyroid problems, diabetes, etc.)? \_\_\_\_\_ NO

13. Blood and Liver (hepatitis, jaundice, liver disease, cirrhosis, sickle cell anemia, blood transfusion, anemia, etc.)? \_\_\_\_\_ NO

14. Immune System (AIDS, HIV Infection, immunodeficiency, etc.)? \_\_\_\_\_ NO

15. Are you presently on a weight reduction program or taking diet pills? If yes, please list names: \_\_\_\_\_ NO

16. Do you have a personal history of blood clots or poor circulation? \_\_\_\_\_ NO

17. Have you ever been diagnosed with cancer? \_\_\_\_\_ NO

a. Treated with chemotherapy? \_\_\_\_\_ NO

b. Treated with radiation? \_\_\_\_\_ NO

18. Have you ever had excessive bleeding with cuts, tooth extraction, pregnancy, surgery, etc.? If yes, please explain: \_\_\_\_\_ NO

19. Have you ever had difficulties with Local or General Anesthesia such as unexplained fever, muscle cramps, dark urine, or pseudo cholinesterase reaction after previous surgeries? If yes, please explain: \_\_\_\_\_ NO

20. Do you have a personal history of a muscle disorder (e.g. muscle weakness) or Malignant Hyperthermia? If yes, please explain: \_\_\_\_\_ NO

**I affirm that the above information is correct to the best of my knowledge.**

\_\_\_\_\_  
Patient's Signature (Parent's if minor)

\_\_\_\_\_  
Today's Date

**Michael D. Yates, MD., PC**  
303 Williams Av. SW, Suite 1421  
Huntsville, Al 35801

**Medical Cost Agreement to Pay**

The patient and responsible party listed below hereby agree to pay all charges submitted by Michael D. Yates, MD, PC., during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with whom the PC has a contractual agreement, the patient and responsible party agree to pay all applicable co-payments with deductibles which arise during the course of treatment for the patient. The patient and responsible party also agree to pay for treatment rendered to patient which is not considered to be a covered service by third party insurers or payors.

The patient and responsible party recognize and agree that their obligations to make payment are joint and severable and that they are responsible for the entire bill, except as stated above, even though the cost of this medical care may exceed the amount reimbursed by third party insurers or payors.

The patient and responsible party agree that in the event that this account must be sent to an outside collection agency as a result of refusal to pay, they will be responsible for all collection costs including a reasonable attorney's fee.

**Release and Statement to permit Payment of Private Insurance benefits to Provider**

I, (We), the undersigned patient and responsible party hereby jointly and severally authorize Michael D. Yates., MD., PC., its agents/employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, (We), authorize the release and disclosure of any and all of my medical records to any other entity, including, but not limited to, referring physicians, hospitals, or other health care providers, which may be of assistance in the opinion of Michael D. Yates., MD, PC., in providing for the treatment of the patient.

I, (We), authorize the release of records necessary to assist in the reimbursement of benefits to which I, (We) may be entitled. I, (We) authorize Michael D. Yates, MD., PC., and/or his employees to release, via mail, fax or electronic data exchange, medical records which are needed in order to provide patient with the most appropriate medical care.

I, (We) authorize and request that payment of any third-party payor or insurance company benefits be made to Michael D. Yates, MD., PC., for any services furnished to patient. The signatures furnished below shall suffice for all insurance forms on a continuing basis.

**Photographic Consent**

I understand that photographs, videotapes, digital or other images may be recorded to document my care, and I consent to this. I understand that Dunagan Yates and Alison Plastic Surgery Center will retain the ownership rights to these photographs, videotapes, digital or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy required by law or outlined in the Dunagan Yates and Alison Plastic Surgery Center's privacy policies. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative. Photos will be released to 3<sup>rd</sup> party payors when predetermination of procedure is required.

Date \_\_\_\_\_ Patient's Signature \_\_\_\_\_ Date of Birth \_\_\_\_\_

Date \_\_\_\_\_ Responsible Party Signature \_\_\_\_\_