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 certif.-icate, 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

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) 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:

_____	_____	_____
Full Name	**DOB**	**Email Address**

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 a 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

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 Hypertension: **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 thought 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 3rd party payors when predetermination of procedure is required.

Date_____ Patient's Signature _____ Date of Birth _____

Date_____ Responsible Party Signature _____