

**A. E. HAAS, M.D.**  
**Plastic and Reconstructive Surgery**  
**Venice Wound Center, Specialty Wound Care**

Patient Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex  M  F

Patient **Local**

Addresses \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Cell Ph # \_\_\_\_\_

**Out of Town Address**

\_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Patient Social Security # \_\_\_\_\_ Marital Status:  S  M  W  D

If above is a minor, parent/guardians's SSN: \_\_\_\_\_

Person Responsible for Payment of Bill \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birth Date \_\_\_\_\_

Address of Above Person \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**My initial visit today will be paid by:**  CHECK, I have my checkbook in hand  
 Cash, I have adequate cash on hand  
 VISA or  MasterCard or  American Express - I have my card in hand

Patient Spouse or Nearest Relative \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birth Date \_\_\_\_\_

Address of Above Person \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Patient's Occupation \_\_\_\_\_ If retired, previous occupation or trade: \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Address \_\_\_\_\_  
 City \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Country \_\_\_\_\_

**Medicare or other Primary Insurance**  
 Company Name \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
 Claims Office Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 ZIP \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**Secondary Insurance**  
 Company Name \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
 Claims Office Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 ZIP \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**Name** of policy holder \_\_\_\_\_  
 Date of birth of policy holder \_\_\_\_\_  
 Deductible Amount \$ \_\_\_\_\_

**Name** of policy holder \_\_\_\_\_  
 Date of birth of policy holder \_\_\_\_\_  
 Deductible Amount \$ \_\_\_\_\_

**PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION (Including HIV) AND CLAIM PAYMENT AUTHORIZATION:**  
 I hereby authorize the above physician to release any information by phone, letter or FAX regarding services rendered by him and a photocopy of my signature to be used to file insurance. I also authorize medical photographs to be taken for patient medical records. I agree to pay any assessments to the bill incurred if collection problems occur. I authorize and direct any medical payments to be made directly to the physician and I am financially responsible for all fees for services rendered. I authorize other physicians offices to forward medical records to Dr. Haas' office as needed. The doctor may speak to any person for my care including other physicians offices and doctors to forward medical records to Dr. Haas' office as needed.

Date \_\_\_\_\_ Signature **X** \_\_\_\_\_  
 Patient  Parent if minor or Guardian

**SEE REVERSE SIDE**

**Insurance companies always reimburse less than you would expect. Ask about your fees.**

List medicines you are allergic to:	Date -last Tetanus shot:	Date:	Have you had any of the following:		Yes No	
	All previous surgeries:	Dates:	Stroke			Back pain or injury
List your current medicines:	Dose & frequency		Epilepsy/convulsions			Slipped disc
			Migraine			Thyroid problems
			Rheumatic fever			Ulcers
			Leukemia			Psychiatric Problems
			Tuberculosis or TB			AIDS / HIV
			Bronchitis			High Blood Pressure
			Emphysema			Heart murmur
			Pneumonia			Chest Pains/Angina
			Asthma			Heart attack(s)
			Hay Fever			Anesthesia Problems
			Lung Disease			Skin Cancer
			Shortness of Breath			Other Cancer-List:
			Frequent nose bleeds			
			Bleeding Problems			Any other illnesses. List:
		Yes No	Anemia			
	Do you drink alcohol?		Diabetes			Family History:
	per/day _____		Hepatitis			
	per/week _____		Liver Disease			
	Do you smoke		Jaundice			
	Packs/day _____		Kidney disease			
			Arthritis			

Explanation of above findings: \_\_\_\_\_

**Today's date:** \_\_\_\_\_ Your age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Right handed\_\_ or Left handed\_\_

**Reason for Consultation:** \_\_ Work injury \_\_ Auto Accident \_\_ Cosmetic \_\_ Other \_\_\_\_\_

What is the Injury or Problem \_\_\_\_\_

Date Injured \_\_\_\_\_ or **About when** was problem first noticed \_\_\_\_\_

What Physician or Person Referred you \_\_\_\_\_ or \_\_ Self Referral

\*\* How did you find out about us? \_\_ Doctor or \_\_ Friend-Who? \_\_\_\_\_ \_\_ Yellow pages : \_\_ Sarasota  
 \_\_ Venice  
 \_\_ Englewood  
 Internet Web Page \_\_\_\_  
 Hospital referral service: \_\_ Venice \_\_ Emergency room : \_\_ Venice  
 \_\_ Englewood \_\_ Englewood  
 Hospital Brochure: \_\_ Venice \_\_ Englewood \_\_ Newspaper \_\_ TV \_\_ Lecture series

Name of your **family doctor** \_\_\_\_\_  
 If you do not have a regular family doctor, we **strongly** urge you to get one for routine exams and referrals to appropriate doctors when needed.

**Your local pharmacy** is \_\_\_\_\_ Phone \_\_\_\_\_ Location \_\_\_\_\_

We try to maintain privacy but people will see your name on our sign up sheet at the front office. If this is not OK with you then do not sign in and let us know that you are here but not signed up. It is also possible that another person may see your chart lying on a desk. We make every attempt to keep others from seeing the contents.