ThorntonMD
Breast. Body. Beautiful

315 East Broadway Suite 310
Louisville KY 40202
(O) 502-629-2610
(P) 502-629-2605

*Patient Name:*_____*Date:*_____
*Address:*_____
Street, Apt # *City* *State* *Zip*
*Social Security #:*_____-_____-_____ *DOB:*_____ *Age:*_____
*Phone:*_____*Home/Cell Other Phone:*_____
*Email:*_____
May we send information to your email address _____*Yes* _____*No*
*Employer:*_____
*Spouse/Partner Name:*_____*Phone:*_____
*Emergency Contact:*_____*Phone:*_____

*Primary Health Insurance*_____
*Subscriber's Name*_____*DOB*_____*SS#*_____

*Secondary Health Insurance*_____
*Subscriber's Name*_____*DOB*_____*SS#*_____

Financial Policy & Patient Responsibility

I understand that I am financially responsible for all charges incurred in this office. I authorize ThorntonMD to bill my insurance company directly, however this does NOT transfer my financial obligation to my insurance company. I understand that ThorntonMD will bill me for my balance left after my insurance company pays this office and all applicable write-offs have been taken or for the entire balance should my insurance company deny reimbursement. I acknowledge my financial responsibility for fees not paid by this assignment and agree to pay any late fees collection agency fees and/or legal fees, if my account becomes delinquent.

Signature_____ ***Date***_____

Special Consent Form

I _____ *give ThorntonMD my permission to use photographs, x-rays, etc for the use of studies, on the website, and/or for teaching/promotional purposes, etc. The information that is used could contain minimum necessary protected health information (PHI), which would not include information such as name, address or phone numbers related to you as an individual. I understand that i do not have to sign this authorization in order to receive treatment from ThorntonMD. I have the right to refuse to sign this authorization. When my information is used or disclosed, pursuant to this authorization, the information may be subject to re-disclosure by the recipient and may no longer be protected but the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing, except to the extent that the practice has acted in reliance upon this authorization.*

Signature_____ ***Date***_____

Notice of Privacy Practices has been received

Signature_____ ***Date***_____

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*Patient Name:*_____ *Date:*_____

*Drug Allergies and Reaction:*_____ *None*_____

Current Medications	***Reason Prescribed***

Previous Surgery	***Year***	***Previous Surgery***	***Year***

*Adverse Anesthesia Reactions*_____

Do you drink alcohol? _____*No* _____*Yes* *Do you form Keloids?* _____*No* _____*Yes*
Do you get infections easy? _____*No* _____*Yes* *Do you bleed easy?* _____*No* _____*Yes*
Do you smoke? _____*No* _____*Yes* *Do you use E-Cigs?* _____*No* _____*Yes*
Are you allergic to Latex? _____*No* _____*Yes*
History of Autoimmune disease? _____*No* _____*Yes*
Have you ever had an MRSA infection? _____*No* _____*Yes*
Do you have an Advanced Care Directive? _____*No* _____*Yes*
*When was your last Flu Vac?*_____*Have you ever had a Pneumonia Vac and When?*_____

*Height*_____ *Weight*_____ *Body Mass Index*_____