ROBINSON
COSMETIC SURGERY

OFFICE 303.792.2828
FAX 303.792.3328

10375 Park Meadows Drive, Suite 150
Lone Tree, Colorado 80124
www.robinsoncosmeticsurgery.com

PATIENT INFORMATION

Date: _____

Name: _____ Preferred name: _____
Last First MI

Birthdate: ___/___/____ Age: ____ **Social Security #:**_____
□ Male □ Female □ Single □ Married □ Divorced □ Widowed □ Separated

Home Address: _____
Street City State Zip

E-mail address _____ OK to use email (unsecure) to contact? □ Yes □ No
OK to send referring offices information via email? □ Yes □ No

Home Phone (___) _____ Cell Phone (____) _____ Ok to use unsecure text to contact? □ Yes □ No

Employer: _____Occupation: _____

Employer Address: _____
Street/PO Box City State Zip

□ Full-time Student □ Part-time Student

Emergency Contact

Name: _____**Phone:** _____ **Relation:** _____
Address: _____
Street City State Zip

Spouse Information

Name: _____ **Employer:** _____
Phone: (_____) _____/_____ **Work #: (____)_____/_____**

Person Responsible for Account (if other than self)

Name: _____ **Relation:** _____
Employer: _____ Social Security #: _____
Billing Address: _____
Street City State Zip

Home Phone: (____)_____/_____ Work Phone: (____)_____/_____

Whom may we thank for referring you?
Name: _____ Phone #: (_____) _____/_____

Please provide the following:

Physician's Name: _____ Phone#: (_____) _____/_____

Dentist Name: _____ Phone #: (_____) _____/_____

Orthodontist Name: _____ Phone #: (_____) _____/_____

MEDICAL HISTORY

Height _____ Weight _____

Do you use tobacco products? □ Yes □ No If yes, how often: _____

ALLERGIES: are you allergic to any of the following? (circle)

Aspirin	Erythromycin	Sedatives	Barbiturates	Codeine
Jewelry / Metals	Sulfa Drugs	Latex	Tetracycline	
Dental Anesthetics	Penicillin	Other _____		

For Women: Are you taking birth control pills? □ Yes □ No Are you pregnant? □ Yes □ No

MEDICATIONS: (Please list current medications)

_____

_____

PREVIOUS SURGERIES:

_____

_____

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Difficulty Breathing	Y N Herpes	Y N Shingles
Y N Alcohol Abuse	Y N Drug Abuse	Y N High Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Emphysema	Y N HIV+/AIDS	Y N Sinus Pressure
Y N Arthritis	Y N Epilepsy	Y N Kidney Problems	Y N Steroid Therapy
Y N Artificial Bones/joints	Y N Pacemaker/defibrillator	Y N Liver Disease	Y N Stroke
Y N Artificial Valves	Y N Fever Blisters	Y N Low Blood Pressure	Y N Thyroid Problems
Y N Asthma	Y N Glaucoma	Y N Lupus	Y N Tonsillitis
Y N Blood Transfusion	Y N Hay Fever	Y N Mitral Valve Prolapse	Y N Tuberculosis (TB)
Y N Cancer	Y N Headaches	Y N Persistent Cough	Y N Ulcers
Y N Chemotherapy	Y N Heart Attack	Y N Psychiatric Problems	Y N Venereal Disease
Y N Chicken Pox	Y N Heart Murmur	Y N Radiation Treatment	Y N Fainting Spells
Y N Colitis	Y N Heart Surgery	Y N Rheumatic Fever	Y N Hospitalized for any reason
Y N Congenital Heart Defect	Y N Hemophilia	Y N Scarlet Fever	
Y N Diabetes	Y N Hepatitis	Y N Seizures	Reviewed:_____

MEDICAL INSURANCE: (Please provide card)

Insurance Company**:** _____ Phone #: _____

Name of Insurance Holder: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Insured's SS#:_____

Employer: _____ Policy or ID#:_____ Group#:_____

DENTAL INSURANCE: (Please provide card)

Insurance Company: _____ Phone #:_____

Name of Insurance Holder: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Insured's SS#: _____

Employer: _____ Policy or ID#: _____ Group#: _____

I have been informed and understand that any services provided to, or performed on me, or my minor child for whom I assume financial responsibility, may not be covered, either fully or partially, by my participating insurance policy. I agree to accept full financial obligation for all such charges associated with professional services rendered at Robinson Cosmetic Surgery, LLC. I understand that Robinson Cosmetic Surgery cannot file an insurance claim without this authorization. I affirm that all information provided is correct to the best of my knowledge. All payments are due in full at time of service.

I authorize the release of any medical or other information necessary to process my insurance claim.

Signature of patient or authorized representative: _____

Date: _____ Printed name of financial guarantor: _____

Robinson Cosmetic Surgery

Health and Dental Insurance – Out-of-Network Notification

Patient: _____ Date: _____

PLEASE INITIAL EACH STATEMENT BELOW

_____This is to confirm that I have been informed that Dr. Randolph C. Robinson does not contract with any medical or dental insurance, except for Delta Dental Premier and Cigna Dental. He is out-of-network for ALL medical insurance companies.

_____ It is the current policy of the office of Robinson Cosmetic Surgery to collect payment in full for all services rendered – **to be paid prior to or at the time of service**.

_____ If I have provided current insurance information to the office of Robinson Cosmetic Surgery, I understand that a claim will be submitted to my insurance carrier for the actual services received. THIS DOES NOT MEAN THAT I AM GUARANTEED COVERAGE OR PAYMENT FROM THE INSURANCE COMPANY.

_____I fully understand that I am financially responsible for ALL services rendered today and in the future, up to and including fees for pre-operative visits, actual surgery costs and post-operative care. This may include services performed by Robinson Cosmetic Surgery for which I am billed after I have left the office.

_____Should I have any questions or concerns, I can request a financial consultation with the Billing Manager or Business Manager of Robinson Cosmetic Surgery.

_____ _____

Patient Signature Staff Review