PATIENT INFORMATION

Name: _____ Age: _____ DOB: _____ SS#:_____

Home Address: _____ City: _____ St_____ Zip_____

Email Address: _____ Phone(s): H) _____ C)_____

Married: _____ (Partner :_____) Single: _____ Widowed: _____ Divorced: _____

Employer: _____ Work Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

REASON FOR VISIT: _____**REFERRING PHYSICIAN:** _____

Have you consulted another plastic surgeon for this issue? _____

MEDICATIONS:

Please list **ALL** (including over-the-counter) medications that you are currently taking including the dosages:

_____

MEDICAL HISTORY:

Height: _____ Weight:_____ Race: _____ Ethnicity: _____

Your primary physician's name: _____ Phone:_____

Please list all serious illnesses:

_____

_____

Do you have: Diabetes_____ Heart Disease _____ Skin cancers_____ Blood clot(s) of the leg _____

High Blood Pressure_____ Heart murmur _____ Bleeding problems_____ Pulmonary embolism_____

** **MEDICATION ALLERGIES**: _____

PREVIOUS SURGERY:

_____

FAMILY AND SOCIAL HISTORY:

Have you or a family member ever had complications from anesthesia?_____

_____

Have you or a family member ever had a serious illness (including parents and siblings)?_____

_____

What is your approximate daily consumption of the following:

Tobacco_____ Alcohol_____

OVER →

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare and/or other insurance benefits be made on my behalf for any services furnished to me by my plastic surgeon. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents or any other insurance company, any information needed to determine these benefits for related services. I hereby authorize payment directly to my plastic surgeon of benefits otherwise payable to me. I understand and agree that any unpaid balance not covered by insurance will be payable by me and/or the primary policy holder.

Signature (**X**)_____ **Date** _____

Guarantor Signature (Primary Policy Holder)

Signature (**X**)_____ **Date** _____

RELEASE OF INFORMATION TO PHARMACY

Pharmacy Name: _____ **Location**: _____ **Phone**: _____

I authorize the pharmacy identified above fill any prescriptions sent by this physician and permit them to disclose health related information, including HIV-related information, and/or information relating to substance abuse treatment and/or mental health diagnoses and treatment and that by signing this form, I am authorizing such information to be disclosed.*

***This authorization will expire one year from the date of signature and we then will need a new one signed**.

Signature (X) _____ **Date** _____

MEDICAL INFORMATION DISCLOSURE:

In connection with the medical services that I am receiving from the above-named physician, I hereby authorize the above-named physician to disclose any and all information concerning my medical condition and treatment, including copies of applicable hospital and medical records to any third party payor covering the medical services of the patient, other health care professionals and institutions involved in the delivery of healthcare to the patient, the proponent of any legally sufficient subpoena, or in response to a court order, employees and agents of the practice, to the degree necessary to facilitate the provision of healthcare services and payment for such services, pharmacies and as otherwise required by law.

List any and all people with whom we can disclose your health information. If they are not listed here, we will not be able to speak with them unless we have written authorization from you.

_____

_____

_____

SPECIAL RESTRICTIONS: _____

This consent is valid from the date executed until revoked in writing by the patient.

Signature (X)_____ **Date**_____ **Witness** _____

I have received a copy of the HIPAA Notice of Privacy Practices.

Signature (**X**)_____ **Date** _____

REVIEW OF SYSTEMS

Do you have or have you had any of the following? Check the box if yes and we will review this with you.

NAME:_____ **DOB:**_____ **Today's Date:** _____

OPHTHALMOLOGIC:
- ☐ Excessive tearing
- ☐ Restricted visual field
- ☐ Blurred vision
- ☐ Discharge
- ☐ Dry eyes
- ☐ Itching and/or redness
- ☐ Pain

ENT:
- ☐ Congestion
- ☐ Blocked ear
- ☐ Difficulty breathing
- ☐ Nosebleed

ENDOCRINE:
- ☐ Excessive sweating
- ☐ Excessive thirst
- ☐ Frequent urination

RESPIRATORY:
- ☐ Asthma
- ☐ Emphysema
- ☐ Chest pain
- ☐ Cough
- ☐ Hemoptysis
- ☐ Shortness of breath
- ☐ Wheezing

BREASTS:
- ☐ Lumps
- ☐ Pain
- ☐ Swelling
- ☐ Nipple discharge
- ☐ Skin rashes/changes
- ☐ Previous biopsy
- ☐ Previous mammogram
- ☐ Previous surgery
- ☐ Self-examination

CARDIOVASCULAR:
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular heartbeat
- ☐ Shortness of breath

GASTROINTESTINAL:
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody stools

GENITOURINARY:
- ☐ Blood in urine
- ☐ Difficulty voiding
- ☐ Frequent voiding
- ☐ Painful voiding

MUSCULOSKELETAL:
- ☐ Muscle aches
- ☐ Shoulder pain
- ☐ Joint pain
- ☐ Arm/hip/knee trauma

PERIPHERAL VASCULAR:
- ☐ Blanching of skin
- ☐ Decreased sensation
- ☐ Painful extremities
- ☐ Ulcerations of the feet
- ☐ Blood clots in legs or pulmonary embolus

NEUROLOGIC:
- ☐ Balance difficulties
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Memory loss

PSYCHIATRIC:
- ☐ Spousal abuse
- ☐ Anxiety
- ☐ Eating disorder
- ☐ Mental/physical abuse
- ☐ Substance abuse
- ☐ Depression

HEALTH EDUCATION:
- ☐ BP screening
- ☐ Diabetes screening
- ☐ Lipid screening
- ☐ Smoking cessation

CANCER SELF-MANAGEMENT:
- ☐ Denies
- ☐ Complaints
- ☐ Skin exam
- ☐ Smoking cessation
- ☐ Use of sunscreen

Comments:

_____

_____

_____

_____

_____

_____

Have you had?
- ☐ Flu Vaccine
- ☐ Pneumonia Vaccine
- ☐ Problems with falls or unsteadiness?

PHYSICIAN SIGNATURE:

_____