

PATIENT INFORMATION FORM

Please Print

Date _____

PATIENT NAME _____ Home Phone () _____

Address _____
Street City State Zip

Email Address _____ Mailing List? Y N Cell Phone _____

Marital Status M S W D Date of Birth _____ Age _____ Sex M F
(circle one)

Social Security No. _____ Driver's License No. _____

Employer _____ Address _____
(If retired, former employer)

Business Phone () _____ May we contact you at work? Yes No a.m. / p.m.

Primary Care Physician _____ Address _____ Phone () _____

Spouse's Name _____ Spouse Date of Birth _____
Last First Initial

Spouse's SS# _____ Employer _____

Employer Address _____ Employer Phone () _____

REFERRED TO THIS OFFICE BY: (circle one)

Yellow Pages Friend Hospital E.R. M.D. Physician's Name _____

Physician Address _____ Phone () _____

Next of kin or emergency contact _____ Phone () _____
Name of friend or relative

Please indicate if any special communication skills will be needed during your appointment
(i.e. sign language, braille, or an interpreter). _____

.....
YOU WILL NEED TO PRESENT YOUR INSURANCE CARD AT THE TIME OF APPOINTMENT
.....

Auto Accident or Workers Compensation

Claim No. _____ Ins Co Name _____

Address _____ Phone _____

ASSIGNMENT OF BENEFITS, INSURANCE BILLING AUTHORIZATION, RECORDS RELEASE

I hereby authorize my insurance benefits to be paid directly to the provider who rendered my services. I realize I am responsible for paying deductibles, copays, any non-covered services, and/or any services disputed by my insurance company, as well as any collection fees. I hereby authorize the release of pertinent medical information necessary to process my claim, which may include mental, physical, prescription, substance abuse, communicable diseases and infections, HIV-related, AIDS, or AIDS related information. I further authorize release of the described pertinent information to other medical providers involved in my care.

Responsible Party _____ Date _____
Signature

Witness _____ Date _____
Signature

Date _____

Specific problems for which you are here today: _____

Have you consulted any other Doctor, including any other Plastic Surgeons for this problem?

Yes _____ No _____ If yes, Physicians Name: _____

PERSONAL HISTORY: Review of systems

Please check the appropriate boxes

Have you ever had

YES NO

YES NO

| | | | | | |
|----------------------------------|--|--|--|--|--|
| Eye disease or eye injury | | | Blood in your urine | | |
| Impaired vision | | | Bone disease or tumors | | |
| Double vision | | | Arthritis | | |
| Facial nerve injury or paralysis | | | Numbness of hands or feet | | |
| Concussion or severe head injury | | | Hand or forearm injury | | |
| Impaired hearing | | | Tendency to form wide scars | | |
| Loss of smell | | | Tendency to form keloids (firm nodular scar) | | |
| Nasal fracture or injury | | | Do you smoke? | | |
| Black-out spells/seizures | | | Have you ever been treated for mental illness? | | |
| Respiratory or lung problems | | | Do you use alcohol? | | |
| Chronic cough | | | Do you faint easily? | | |
| Heart disease or attack | | | Ever been on steroids? | | |
| Rheumatic fever | | | Do you now or have you ever used drugs | | |
| Bleeding tendency | | | or alcohol to excess? | | |
| High blood pressure | | | Do you use aspirin or Motrin on a regular basis? | | |
| Diabetes | | | (not Tylenol) | | |
| Chronic nausea or vomiting | | | Date last aspirin was taken: | | |
| Chronic diarrhea or constipation | | | Are you left or right handed: | | |
| Blood in stools | | | Have you been tested for HIV? | | |
| Bladder or kidney infection | | | Result: positive negative (circle one) | | |
| Skin disease | | | MALES ONLY: | | |
| Gonorrhea or syphilis | | | Prostate disease | | |
| Pneumonia | | | FEMALES ONLY: | | |
| Asthma | | | Number of pregnancies | | |
| Cancer of any kind | | | Number of children | | |
| Hepatitis | | | Miscarriages | | |
| Autoimmune Disease (AIDS, Etc.) | | | Last menstrual period | | |
| | | | Last mammogram, if any | | |

Is there any personal history of serious illnesses or chronic illnesses, if so please list and the years they occurred

How long ago was your most recent physical check-up? _____

Did it include an electrocardiogram? yes _____ no _____, _____ Chest X-rays yes _____ no _____

Any operations or hospitalizations? If so please list below:

| Operation or Hospitalization | Year | Were you put to sleep? |
|------------------------------|------|------------------------|
| 1. _____ | | |
| 2. _____ | | |
| 3. _____ | | |
| 4. _____ | | |

Please list all present medications including herbal supplements and vitamins, birth control pills, cold tablets, prescription drugs, etc. _____

Allergies (medications, latex, shellfish, bananas, kiwi, or other foods, environmental) _____

What is your approximate daily consumption of the following:

Coffee or tea _____

Tobacco _____

Alcohol _____

Other intoxicating or mind-altering substances, Specify: _____

Weight _____ Height _____

Weight loss or gain in the last year _____ pounds lost _____ gained

Please indicate if anyone in your family have had any of the following conditions:

| Please check all that apply | <input checked="" type="checkbox"/> | For all those you checked, please indicate your family relationship in the blanks below |
|--------------------------------------|-------------------------------------|---|
| Cancer | <input type="checkbox"/> | |
| Diabetes | <input type="checkbox"/> | |
| Heart Trouble | <input type="checkbox"/> | |
| Bleeding Tendency/Blood Disease | <input type="checkbox"/> | |
| Mental Illness | <input type="checkbox"/> | |
| Congenital Defects, Cleft Lips, etc. | <input type="checkbox"/> | |

I realize that accurate medical information is absolutely essential to safe and proper medical care and have answered the questionnaire honestly and to the best of my ability.

Signed: _____ Date _____