*account#*_____

PLASTIC SURGERY ASSOCIATES

Patient Information Form- *please print*

Patient Name _____ Date of Birth _____age_____

Address _____ Home phone# _____

City _____ State _____Zip _____ Cell Phone# _____

Email address _____ Marital status M S W D Gender M F

Primary Language_____ Driver's License#_____ Social Security#_____

Employer_____ Occupation_____ Full Time/ Part Time

Address_____

Business Phone# _____May we contact you at work? Yes No

Spouse's Name_____Date of Birth_____Social Security#_____

Employer_____ Employer Phone#_____

Next of Kin/ Emergency Contact _____Phone#_____

Primary Care Physician_____Phone#_____

How did you hear about our office? _____

Please indicate if there is anything we need to know to provide you more personal care_____

_____

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

Is this a Worker's Compensation or Auto Accident? Yes No

Insurance Company _____claim#_____

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.

_____ _____

(patient/parent/guardian signature) *(date)*

_____ _____

(witness signature) *(date)*

☐ **I Have Received a Copy of the Notice of Privacy Practices at Plastic Surgery Associates, patient rights and responsibilities, and the disclosure of ownership.**

acct# _____

PLASTIC SURGERY
ASSOCIATES

What is your main concern(s) for today's discussion?_____

If injury, what was the date of the injury?_____Were X-Rays taken? *Yes No* Where?_____

Have you consulted any other physician for this problem? No Yes- who?_____

Do you have an advanced directive?_____yes _____no If no, you can find information at www.michigan.gov/mdhhs.

*If **YES**, please bring a copy with you on the day of surgery.

_____

Allergies/reaction: _____

Medications(prescription): name, dose, frequency, reason

_____

_____

_____

_____

Over the Counter(herbal supplements/vitamins):

_____

_____

_____

_____

Surgeries/Hospitalizations:

_____date_____

_____date_____

_____date_____

_____date_____

Anesthesia History:

Have you had anesthesia? Yes No
Nausea/Vomiting after? Yes No
Motion Sickness? Yes No
Malignant Hyperthermia?
(self or family) Yes No

Female patients:

Number of Pregnancies _____
Number of Children _____
Most Recent Mammogram_____
Location of Mammogram_____

Social History:

(please indicate daily consumption):
Alcohol_____
Tobacco or Tobacco Products_____
Other intoxicating substances_____

Height_____ How much weight have you ***lost*** in the past year? _____

Weight_____ How much weight have you ***gained*** in the past year? _____

Past Medical History

	yes	no		yes	no		yes	no
Eye Injury			Heart Disease			Diabetes		
Eye Disease			Heart Attack			Thyroid Disorder		
Dry Eye			High Blood Pressure			Numbness of hands/feet		
Impaired Vision			Blood Clots			MRSA		
Blackouts			Bleeding Tendency			TB		
Seizures			Rheumatic Fever			Hepatitis		
Concussion/Head Injury			Cancer			AIDS/HIV		
Facial Nerve Injury			Asthma			AutoImmune Disease		
Wide Scars			Chronic Cough			Gonorrhea		
Keloids			Respiratory Problems			Syphilis		
Gastric Surgery			Pneumonia			Mental Illness		
			Sleep Apnea			Depression/Anxiety		

I realize that accurate medical information is essential for safe and proper medical care. The above information is true and accurate to my best knowledge.

_____ _____

(patient signature) (date)