PATIENT INFORMATION

Version 1/2017

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

DATE OF BIRTH: _____ AGE: _____ MARITAL STATUS: _____ SS#: _____

EMPLOYER NAME _____ EMPLOYMENT STATUS (Circle) Full Time / Part Time / Retired

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMERGENCY CONTACT NAME: _____ PHONE:_____

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

PRIMARY CARE PHYSICIAN NAME & PHONE NUMBER: _____

MEDICAL HISTORY:

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

PREVIOUS SURGERY?: _____

HOSPITALIZATIONS? _____

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

High Blood Pressure_____ Heart murmur _____ Bleeding problems_____ Pulmonary embolism _____

***MEDICATIONS*:**

Please list ALL (Including over the counter) medications that you are currently taking with dosage info:_____

_____

MEDICATION ALLERGIES: _____

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?_____

_____

What is your approximate daily consumption of the following:

Tobacco_____ Alcohol_____

Do you use recreational drugs? If so, please list _____

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 Hiolder)

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 PERMIT, HIPAA PRIVACY NOTICE AND PHOTOGRAPHIC CONSENT:

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 am aware that a copy of the HIPAA Notice of Privacy Practices is available to me and is posted in the waiting room.

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. ❑

PATIENT NAME: _____ **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 ❑
- Diabetes ❑

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

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

CARDIOVASCULAR:
- Chest Pain ❑
- Murmur ❑
- High Blood Pressure ❑
- Irregular heartbeat ❑
- Shortness of breath ❑
- Heart Disease ❑

GASTROINTESTINAL:
- Nausea ❑
- Vomiting ❑
- Diarrhea ❑
- Constipation ❑
- Bloody stools ❑
- Crohn's Disease ❑

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

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

PERIPHERAL VASCULAR:
- Blanching of skin ❑
- Decreased sensation ❑
- Painful extremities ❑
- Ulcerations of the feet ❑
- Blood clots in legs ❑
- Pulmonary embolus ❑
  - Location _____
- Clotting difficulties ❑

NEUROLOGIC:
- Balance difficulties ❑
- Falls in the past year ❑
- Dizziness ❑
- Fainting ❑
- Headache ❑
- Memory loss ❑

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

DERMATOLOGY:
- Basal cell carcinoma ❑
- Squamous cell carcinoma ❑
- Melanoma ❑
- Other ❑

HEALTH EDUCATION:
- Blood Pressure screening ❑
- Diabetes screening ❑
- Lipid screening ❑
- Smoking cessation ❑

SKIN CANCER SELF-MANAGEMENT:
- Deny ❑
- Agree - I see a dermatologist ❑
- Regular skin exam ❑
- Regular sunscreen use ❑

HAVE YOU HAD?
- Flu Vaccine ❑
- Pneumonia Vaccine ❑
- Colorectal screening ❑

WOMEN ONLY
- Urinary incontinance ❑

Comments:

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PHYSICIAN SIGNATURE:

_____

DATE:

_____