



The Plastic Surgery Group

Height \_\_\_\_\_ Weight \_\_\_\_\_

**ALLERGIES : List all)**

Medications	Type of Reaction	Food	Type of Reaction	Environmental	Type of Reaction

**MEDICATIONS:** (include aspirin, hormone replacement, birth control, diet pills, sleep aids, all vitamins, herbs, teas, over-the-counter or alternative therapies)

Medication (name of drug)	Dosage (how much)	Frequency (how often)

**PAST MEDICAL HISTORY :** Do you have now or have you had in the past any of the following:

	YES	NO		YES	NO
Bleeding	___	___	Asthma	___	___
Chronic Cough	___	___	Heart Disease	___	___
High Blood Pressure	___	___	Tuberculosis	___	___
Jaundice	___	___	GI disease	___	___
Hepatitis	___	___	Fever Blisters	___	___
Neurological disease	___	___	Lung Disease	___	___
Steroid use	___	___	Convulsions	___	___
Kidney disease	___	___	History of Blood Clots	___	___
Diabetes	___	___	Family History of Blood Clots	___	___
Rheumatic Fever	___	___	Psychiatric/emotional disorder	___	___
Heavy Scars	___	___			

**LIST OTHER MEDICAL CONDITIONS:** \_\_\_\_\_

If "yes" to any of the above, please provide details. \_\_\_\_\_

\_\_\_\_\_

**PAST SURGERIES/HOSPITALIZATIONS:**

Date	Type of Surgery	Name of Hospital	Doctor

**ANESTHESIA HISTORY:**

Have you ever had a REACTION to a GENERAL anesthetic? (being put to sleep)      Yes      No  
 Has a family member ever had a REACTION to a GENERAL anesthetic?      Yes      No  
 Have you ever had a REACTION to a LOCAL anesthetic? (Novocain, etc.)      Yes      No

If "yes" to any of the above, please provide details. \_\_\_\_\_  
 \_\_\_\_\_

**SOCIAL HISTORY**

Tobacco (cigarettes, cigars, pipe) [list amount/day and # of years smoking]  
 \_\_\_\_\_  
 \_\_\_\_\_

If you ever smoked but don't now, when did you quit?  
 \_\_\_\_\_

Have you been exposed to heavy second hand cigarette, cigar or pipe smoke for an extended period of time on a regular basis in the past two years?      Yes      No

Recreational drugs (type of drug and number of years of use) \_\_\_\_\_  
 \_\_\_\_\_

Alcohol (type, how often) \_\_\_\_\_

**FAMILY HISTORY (list relationship, age, medical problem and if they are living or deceased)**

Mother	Father	Sisters	Brothers

Primary Care MD

Pharmacy

\_\_\_\_\_  
 Name & telephone #

\_\_\_\_\_  
 Name & telephone #

Emergency contact person:

\_\_\_\_\_  
 Name & telephone #

PATIENT /GUARDIAN SIGNATURE: \_\_\_\_\_

RELATIONSHIP OF GUARDIAN TO PATIENT: \_\_\_\_\_

The Plastic Surgery Group does not participate in any insurance plan.

In order to clarify our office policy, we ask that you read and sign the following explanation.

Thank you.

---

The Plastic Surgery Group has advised me that they do not participate with any insurance carrier. I understand that this means they don't accept my insurance as payment in full.

I understand that I am responsible for any charges incurred and will be balance billed for all co-payments, non-covered charges over U&C and deductibles.

X \_\_\_\_\_ Date: \_\_\_\_\_  
Patient/Guardian's signature

X \_\_\_\_\_ Date: \_\_\_\_\_  
Please print patient's name

**ACKNOWLEDGMENT OF RECEIPT  
OF NOTICE OF PRIVACY PRACTICES**

**I acknowledge that I was provided a copy of the Notice of Privacy Practices for  
THE PLASTIC SURGERY GROUP.**

**Print Patient Name:** \_\_\_\_\_

**Signature of Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**\*If person signing is not the patient, please print your name and relationship to patient:**

**Name** \_\_\_\_\_

**Relationship** \_\_\_\_\_

**I (patient or representative) request a copy of the Notice of Privacy Practices:**

**Yes** \_\_\_\_\_ **No** \_\_\_\_\_

---

**For office use:**

**If patient /representative requested copy of Notice, date copy was provided:**

\_\_\_\_\_.

**If no acknowledgment could be obtained, state the reasons why and the efforts taken to try  
to obtain the acknowledgment.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_