



The Plastic Surgery Group

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Mr./Mrs./Miss/Ms./Dr. _____
First Name Middle Last Name Nickname (if used)

Male Female STATUS: Single Married Divorced Widow Other

Street Address City/State Zip Code

(_____) _____ (_____) _____ (_____) _____
Home Telephone Number Business Telephone Number Cellular Telephone Number

_____/_____/_____ _____/_____/_____ _____
Social Security Number Date of Birth Age

Email Address

Employer Name and address _____

REASON FOR VISIT: _____
REFERRED BY: _____

Insurance Info: Worker's Compensation Motor Vehicle Accident Other _____

Name of Insurance Company Subscriber Name Subscriber SS # Subscriber DOB

Primary Care MD Pharmacy

Name & telephone # Name & telephone #

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)

Height: _____

Weight: _____

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

HISTORY	YES	NO
Thyroid Disorder		
High Blood Pressure		
Tuberculosis		
Asthma		
Heart Disease		
Jaundice		
Hepatitis		
Neurological Disease		
Seizure Disorders		
Gastrointestinal Disease		
Kidney Disease/Urinary Problems		
Diabetes		
Fever Blisters		
History of Blood Clots/Bleeding Disorders		
Family History of Blood Clots/Bleeding Disorders		
Psychiatric/Emotional Disorders		
Motion Sickness		
Steroid Use		
Heavy Scars		

LIST OTHER MEDICAL CONDITIONS: _____

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

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



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NOTIFICATIONS & ACKNOWLEDGEMENTS

PRIVACY

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

INSURANCE/ PAYMENT

_____ I hereby acknowledge that in consideration for treatment rendered to me and/or my child or child in my care that I am responsible and will pay for all charges and fees of the doctors of The Plastic Surgery Group for the services rendered. 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 and that I am responsible for any charges incurred. All payments are due within thirty (30) days of receipt of the bill. I understand that if this account is placed to a third party collection agency and/or attorney I am responsible for all costs of collection and interest as allowed by law.

AUTHORIZATION

_____ I hereby authorize the doctors of The Plastic Surgery Group to release any information acquired in the course of my examination or treatment and further authorize payment of the surgical and/or medical benefits directly to the physicians.

AUTHORIZATION TO PHOTOGRAPH

_____ I hereby grant authority to the doctors of The Plastic Surgery Group to take pre and post operative photographs for insurance documentation or internal use only. Photographs will **not** be used for publication without additional special consent or notification.

Print Patient Name: _____

Signature of Patient/Guardian: _____

Date: _____