NEUGENESIS PLASTIC SURGERY

PATIENT INFORMATION

NAME: ____
LAST FIRST INITIAL

ADDRESS: ____
STREET CITY, STATE ZIP

TELEPHONE: (_____)_____________________ SS#: __________-_________-_____________

CELL: (_____)_____________________

BIRTHDATE: _____/______/______AGE: _______SEX: _____DRIVER LIC#_____________

EMPLOYER: ______________________________ OCCUPATION: _______________________

ADDRESS: ________________________________

CITY, STATE & ZIP ________________________ PHONE #: (____)______________________

SPOUSE: ____________________________________PHONE #: _________________________

EMERGENCY CONTACT: ___________________________ PHONE #: ___________________

RELATIONSHIP: ________________________________

- REFERRING PHYSICIAN: ____
  PHONE #: (____)_______________ ADDRESS: ________________________________
  ____
  REASON FOR REFERRAL: ____
- PRIMARY CARE PHYSICIAN: ____
  PHONE #: (____)_______________ ADDRESS: ________________________________
  ____

INSURANCE INFORMATION

PRIMARY INS: ____________________________SUBSCRIBER: _______________________

ID#: ____GROUP#: _________________________

RELATIONSHIP TO SUBSCRIBER: ____

2ND INS: ____________________________________SUBSCRIBER: ______________________

ID#: ____GROUP#: _________________________

IF PATIENT IS A MINOR – COMPLETE THIS SECTION

GUARDIAN'S NAME: ____

SS#: ______-______-________ EMPLOYER PHONE#: (_____)_________________________

SIGNATURE: __________________________________DATE: __________________________

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PATIENT MEDICAL HISTORY

CIRCLE "Y" FOR YES AND "N" FOR NO, OR WRITE YOUR RESPONSE ON THE APPROPRIATE LINE.

NAME: ______________________________

AGE:_________ WT:______HT:__________

ALLERGIES TO MEDICATIONS:

____

____

____

CURRENT MEDICATIONS: ____________

____

____

____

____

CIGARETTE PACKS /DAY

____

ALCOHOLIC DRINKS / WEEK

____

LIST ALL OPERATIONS
AND YEAR OF SURGERY: ___________

____

____

____

____

HAVE YOU HAD ANY PROBLEMS WITH ANESTHESIA IN THE PAST? DESCRIBE?

____

____

____

DO YOU HAVE HIGH BLOOD PRESSURE?
Y N

HAVE YOU EVER HAD A STROKE OR TEMPORARY BLACK OUT?
Y N

DO YOU HAVE HIGH CHOLESTEROL?
Y N

DO YOU HAVE THYROID DISEASE?
Y N

DO YOU HAVE LIVER DISEASE (CIRRHOSIS OR HEPATITIS)?
Y N

HAVE YOU HAD A HEART ATTACK OR CONGESTIVE HEART FAILURE?
Y N

DO YOU GET PALPITATIONS?
Y N

DO YOU HAVE A PACE MAKER?
Y N

DO YOU HAVE ASTHMA?
Y N

DO YOU HAVE BRONCHITIS?
Y N

DO YOU HAVE EMPHYSEMA?
Y N

DO YOU HAVE HISTORY OF PNEUMONIA? Y N

DO YOU HAVE STOMACH PROBLEMS:

ULCERS? Y N

HEART-BURN? Y N

BLEEDING? Y N

DO YOU HAVE A HIATAL HERNIA?
Y N

DO YOU GET CHEST PAINS?
Y N

HAVE YOU EVER BEEN TREATED FOR ANEMIA? Y N

HAVE YOU EVER HAD A TRANSFUSION?
Y N

DO YOU HAVE DIABETES?
Y N

(HOW LONG?) ________

DO YOU HAVE ANY HISTORYOF CANCER?
Y N

REASON FOR VISITING PLASTIC SURGEON:

____

____

FOR FEMALE PATIENTS ONLY:

DO YOU TAKE BIRTH CONTROL PILLS?
Y N

FOR YOUR SAFETY, ARE YOU AT RISK
FOR PREGNANCY?
Y N

DATE OF LAST MENSTRAL PERIOD
_______/_______/________

FOR PEDIATRIC PATIENTS ONLY:

HAS YOUR CHILD HAD A RECENT COLD, FEVER,
OR SORE THROAT?
Y N

ALL PATIENTS:

I authorize the release of any medical information necessary to process the claim and request that payment of all benefits be made to the undersigned physician for services provided. **I understand that I am financially responsible for non-covered benefits and all deductibles not covered by this authorization.** Should the account be referred to an attorney for collection, the undersigned shall pay actual attorney's fees and collection expenses.

____ ___________________
Signed (insured or authorized person) Date

____ ___________________
Reviewed by Doctor: Date

- It is your responsibility to notify us of any changes, including telephone number, address, and/or insurance information. Please return this form to the receptionist.
  Thank you for your cooperation.