PATIENT REGISTRATION FORM

PATIENT NAME: ______________________________

P.O. BOX: ____________ STREET ADDRESS: ______________________

CITY: ____________ STATE: ______ ZIP: ________ PHONE: ____________

EMAIL: ______________________ CELLPHONE: ____________

SEX: M F MARITAL STATUS: ❑ MARRIED ❑ SINGLE ❑ SEPARATED ❑ DIVORCED ❑ WIDOW(ER)

DATE OF BIRTH: ____________ SS# ____________ STUDENT STATUS: ❑ FULL ❑ PART-TIME

EMPLOYMENT STATUS: ❑ NONE ❑ PART-TIME ❑ FULL TIME ❑ RETIRED

EMPLOYER: ______________________ PHONE: (____) ____________

SPOUSE'S NAME: ____________ SS#: ____________ DOB: ____________

EMPLOYER: ______________________ PHONE: (____) ____________

(IF PATIENT IS A CHILD FILL OUT THE FOLLOWING)

FATHER'S NAME: ______________________ PHONE: (____) ____________

FATHER'S EMPLOYER: ______________________ PHONE: (____) ____________

FATHER'S SS#: ______________________ DATE OF BIRTH: ____________

MOTHER'S NAME: ______________________ PHONE: (____) ____________

MOTHER'S EMPLOYER: ______________________ PHONE: (____) ____________

MOTHER'S SS#: ______________________ DATE OF BIRTH: ____________

1ST INSURANCE COMPANY: ____________ POLICY #: ____________ GROUP # ____________

INSURED'S NAME: ______________________ RELATIONSHIP: ____________

2ND INSURANCE COMPANY: ____________ POLICY #: ____________ GROUP # ____________

INSURED'S NAME: ______________________ RELATIONSHIP: ____________

IN CASE OF AN EMERGENCY, NOTIFY

NAME: ______________________ RELATIONSHIP: ____________

ADDRESS: ______________________ CITY: ____________

STATE: ______ ZIP: ________ DAY PHONE: ____________ EVENING PHONE: ____________

WHOM MAY WE THANK FOR REFERRING YOU?

❑ PHYSICIAN NAME ____________ ❑ YELLOW PAGES NAME ____________

❑ FRIEND/PATIENT NAME ____________ ❑ NEWSPAPER NAME ____________

❑ PUBLIC MEETING LOCATION ____________ ❑ INTERNET WEB ADDRESS ____________

❑ OTHER NAME ____________

(OVER)

PATIENT REGISTRATION FORM

I, ____, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistant or staff as may be assigned by him/her.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize that taking of photographs at the direction of my surgeon and under such conditions as may be approved by him/her. These photographs will be used solely for documentation purposes and will be kept confidential.

I agree I am responsible for all charges for goods and services rendered by Eastern Shore Plastic Surgery, P.C. Including reasonable attorney's fees and cost of collection in the event of default.

I understand that there may be a consultation fee for the initial visit which is due at the time of my appointment unless other arrangements have been made in advance.

SIGNATURE:__________________________________ DATE:_________________________

RELATIONSHIP: (circle one) PATIENT SPOUSE PARENT GUARDIAN

If you have a second home you reside in for part of the year, please list that address and telephone number below.

Home / P.O. Box Address:____

City ____________________________________ State _______________________ Zip __________

Telephone: ____

Patient's Personal History

Date: ____________

Last Name: ____________________ First Name: __________________ Middle Name: ________________

Age: _______ Height: ________ Weight: ________ Sex: M F Marital Status: S M W D Sep.

Are you allergic to any medications? ☐**No** ☐**Yes** (please list if yes)

Do you have a latex allergy? ☐**No** ☐**Yes**

Do you take diet pill, appetite suppressant or natural dietary supplements? ☐**Yes** ☐**No** (If yes, stop taking two weeks before surgery.)

Physician Information:

Referring Physician: __________________________ **Address:** ______________________________

Family Physician: ____________________________ **Address:** ______________________________

Date of Last Physical: ________________________

DO YOU HAVE OR HAVE YOU HAD: (Circle – if yes, give date of occurrence)

Arthritis.............No Yes _____	Congenital Heart........No Yes_____	Leukemia..................No Yes_____
Asthma...............No Yes_____	Diabetes...................No Yes_____	Migraine..................No Yes_____
AIDS or HIV..........No Yes _____	Epilepsy...................No Yes ____	Nervous Breakdown.....No Yes _____
Back Problems......No Yes_____	Goiter......................No Yes_____	Pneumonia.................No Yes_____
Bladder Infection...No Yes_____	Hay Fever.................No Yes_____	Rheumatic Heart.........No Yes_____
Bleeding Tendency..No Yes_____	Heart Attack.............No Yes_____	Stomach Ulcers...........No Yes_____
Bronchitis............No Yes_____	Hepatitis...................No Yes_____	Stroke.........................No Yes_____
Cancer..................No Yes_____	High Blood Pressure....No Yes_____	Tonsillitis....................No Yes_____
Colitis..................No Yes_____	Kidney Disease..........No Yes_____	Tuberculosis................No Yes_____

Other serious illness which you have: ____

Do you smoke? Y N How much? __________ Do you regularly drink 6 or more cups of coffee per day? Y N

Do you regularly drink alcohol or beer? Y N How much __________ Date of last chest x-ray: ____________

DO YOU KNOW OF ANY BLOOD RELATIVE WHO HAS

Arthritis ________	Epilepsy ________	Leukemia ________
Asthma ________	Goiter ________	Migraine ________
Bleeding Tendency ________	Hay Fever ________	Nervous Breakdown ________
Breast Cancer ________	Heart Attack ________	Rheumatic Heart ________
Other Cancer ________	High Blood Pressure ________	Stomach Ulcers ________
Colitis ________	High fever after surgery ______	Stroke ________
Congenital Heart Disease ______	Insanity ________	Suicide ________
Diabetes ________	Kidney Disease ________	Tuberculosis ________

Please list the names and year of any operations you have ever had:

____

____

____

PLEASE LIST ANY MEDICATIONS THAT YOU HAVE TAKEN WITHIN THE LAST MONTH. PLEASE SPECIFY. (Prescription or Over-The-Counter)

____________ ____________ ____________

____________ ____________ ____________

____________ ____________ ____________

Have you ever had any complications from anesthesia? Y N Explain: ____________

Serious injuries or accidents: ____________

Do you frequently have bleeding gums?	Y	N	
Do you have nose bleeds?	Y	N	How often? ________
Have you ever bled excessively from a tooth extraction?	Y	N	
Do you bleed excessively from a laceration?	Y	N	
Have you had blood transfusions?	Y	N	Any adverse reactions? ________
Do you take aspirin regularly or ibuprofen or vitamin E?	Y	N	How Often? ________
		(If yes stop taking one week before surgery)	

WOMEN ONLY

Is there any chance you may be pregnant? Y N

How many pregnancies? ____________

How many children born alive? ____________

How many cesarean operations? ____________

Any complications with pregnancy? ____________

Date of last breast exam: ____________ Results: ____________

Date of last mammogram: ____________ Results: ____________

Note: We recommend a regular breast and pelvic exams by your regular physicians for all adults.