collins
PLASTIC SURGERY

new patient information

All questions contained in this questionnaire are strictly confidential and will become a part of your medical record. Please respond with "N/A" if you wish to abstain from answering a particular question.

PATIENT DETAILS

Name: _____
Last First MI

Address: _____
Street City State Zip Code

Phone: (_____) _____-_____ (_____) _____-_____ (_____) _____-_____
Home Cell Work

Email: _____ Is this your first visit to our office? O yes O no

DOB: _____/_____/_____ Age: _____ Sex: O female O male

Employer: _____ Employer Address: _____

Referred by: O Name _____ O Location/walk-by

O Web search (specify) _____ O Advertisement (specify) _____

Reason for your visit to Collins Plastic Surgery _____

In case of emergency, please contact:

Name: _____ Phone: (_____) _____-_____ Relationship: _____

Preferred Pharmacy _____ Phone: (_____) _____- _____

INSURANCE INFORMATION

Does your insurance company require a referral for this appointment? O yes O no

Date of injury/accident (if applicable) _____/_____/_____ ER in which you were seen: _____

Are you currently under hospice care? O yes O no

Are you the Primary Insurance holder? O yes O no If not, please complete the information below:

Policy Holder or Responsible Party (if not you): _____

DOB: _____/_____/_____ Social Security #: _____-_____-_____ Relationship: _____

Address: _____
Street City State Zip Code

Phone: (_____) _____-_____ Employer: _____
Main

Is this a work-related injury? O yes O no Is this an attorney-referred appointment? O yes O no

Please continue on back page...

PATIENT HEALTH AND MEDICAL HISTORY

Height _____ Weight _____ Medical Doctor _____

Select any of the following medical conditions that you currently have:

O Adrenal Insufficiency
O Anemia/Thalassemia
O Anxiety
O Arthritis
O Asthma
O Atrial Fibrillation (Irreg. heartbeat)
O Auto-Immune Disease
O Bipolar Disorder
O Blood Clotting Disorder
O BPH
O Breast Cancer
O Colon Cancer
O COPD
O Coronary Artery Disease
O Deep Venous Thrombosis
O Depression
O Diabetes
O Easy Bruising
O End Stage Renal Disease
O GERD
O Head Trauma
O Hearing Loss
O Hepatitis
O Hypertension
O HIV/AIDS
O Hypercholesterolemia
O Hyperthyroidism
O Lung Cancer
O Lupus
O Lymphoma
O Malignant Hypertension
O Mental Health Hospitalization
O Neuromuscular Disorder
O Paralysis
O Pneumothorax
O Prostate Cancer
O Pulmonary Embolism
O Radiation Treatment
O Renal Disorder
O Rheumatoid Arthritis
O Seizures
O Sever Reaction to Anesthesia
O Stroke
O Trauma
O Valvular Heart Disease
O Vision Loss
O Other _____
O None

Have you ever seen a cardiologist? O yes O no

Have you had any general surgery? O yes O no If so, what procedure(s)? _____

Do you have any skin conditions or disorders? O yes O no

If so, please list them: _____

Do you have a family history of melanoma? O yes O no If so, which relative(s)? _____

Please list any past plastic surgery procedures: _____

_____

Do you have a family history of breast cancer? O yes O no If so, which relative(s)? _____

Do you have a family history of malignant hyperthermia or severe reactions to anesthesia? O yes O no

If so, which relative(s)? _____

Do you take herbal medications/supplements? O yes O no If so, which one(s)? _____

Please list all medications you now take (include any over-the-counter medications):

MEDICINE NAME	DOSAGE	DAILY

Please list any allergies: _____

Are you allergic to latex? O yes O no

Do you smoke? O yes O no If so, how regularly do you smoke? _____

Do you drink alcohol? O yes O no If so, how many drinks per week on average do you consume? _____

By signing below, I have stated all known medical conditions and take full responsibility to inform the medical team at Collins Plastic Surgery and Synergy of any and all new information regarding my physical condition and health. Furthermore, I authorize Collins Plastic Surgery and Synergy to have access to my patient files for the purposes of assessing, recommending, and performing the most effective and proper services for me.

Signature _____ Date _____/_____/_____