

PRIMA CENTER FOR PLASTIC SURGERY

PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Name: _____ Date of Birth: _____ Age: _____
Legal First Middle Last

Address: _____ Cell Phone: _____

City: _____ State _____ Zip _____ Home Phone: _____

Email Address: _____ Work Phone: _____

Family Doctor: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Name of person(s) we have permission to discuss your care with: _____

Phone #: _____ Relationship to Patient: _____

BILLING INFORMATION (if patient is a minor, please include both parents' names)

Billing Name: _____ Spouse's Name: _____

Insurance: _____ Address: (if different) _____

ID#: _____

Group#: _____ Phone #: _____ Employer: _____

Name of person or relative (not living with you) we can Employer Address: _____

contact in an emergency: _____ Employer Phone #: _____

Phone #: _____ Alternate #: _____

PRIVACY POLICY

Our Privacy Notice is located in the reception area. Your signature below indicates you have had the opportunity to review the privacy notice.

Patient/Responsible Party Signature

Date

NON-ELECTIVE MEDICAL SERVICES

Primary Insurance Company: _____ Secondary Insurance Company: _____

Please provide your Insurance Card(s) for photocopy services

I hereby authorize Prima Center for Plastic Surgery to furnish information to my insurance company or companies. I hereby assign Prima Center for Plastic Surgery all payments for medical services rendered to my dependents, or myself and I understand that I am responsible for any amount not covered by insurance.

Patient/Responsible Party Signature

Date

PRIMA CENTER FOR PLASTIC SURGERY

Legal Name: _____ Age: _____ Today's Date: _____

Date of Birth: _____ Sex: _____ Height: _____ Weight: _____

DRUG ALLERGIES: _____ Occupation: _____
(prescriptions, latex, dyes, etc.)

PURPOSE OF VISIT

What is the reason for your visit today? _____

HEALTH REVIEW

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING (CHECK ALL THAT APPLY)

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nerve Damage |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Blood Clots/DVT (Deep Vein Thrombosis) | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sleep Apnea (CPAP/BiPAP) |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis ___ A ___ B ___ C | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Tuberculosis |

ANY OTHER SERIOUS ILLNESSES / INJURIES / MEDICAL INFORMATION:

HAVE YOU HAD ANY PREVIOUS OPERATIONS?

_____	Year _____	_____	Year _____
_____	Year _____	_____	Year _____
_____	Year _____	_____	Year _____
_____	Year _____	_____	Year _____
_____	Year _____	_____	Year _____

PLEASE LIST MEDICATION(S) YOU ARE CURRENTLY TAKING (if any)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Coumadin | <input type="checkbox"/> Iron | <input type="checkbox"/> Water Pills |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Digitalis | <input type="checkbox"/> Laxatives | <input type="checkbox"/> Weight Reduction Pills |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Dilantin | <input type="checkbox"/> Psychological Meds | <input type="checkbox"/> Other Please List |
| <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Herbal Medicine | <input type="checkbox"/> Sleeping Pills | _____ |
| <input type="checkbox"/> Blood Pressure Meds | <input type="checkbox"/> Hormones | <input type="checkbox"/> Thyroid Medication | _____ |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Insulin | <input type="checkbox"/> Tranquilizers | _____ |
| | | | _____ |

PERSONAL HEALTH

PLEASE CHECK YES OR NO FOR THE FOLLOWING

- | | | | |
|-----|---|-----|--|
| YES | NO | YES | NO |
| ___ | ___ Do you smoke/vape regularly? | ___ | ___ Do you have frequent nosebleeds? |
| ___ | ___ If yes, how many packs per day? ___ # of years? ___ | ___ | ___ Do you bleed excessively from a cut? |
| ___ | ___ Do you drink over 6 cups of coffee a day | ___ | ___ Do you regularly take aspirin? |
| ___ | ___ Do you regularly drink alcoholic beverages? | | |

WOMEN ONLY

- | | |
|-----|---|
| YES | NO |
| ___ | ___ Do you have regular monthly menstrual cycles? |
| ___ | ___ Do you have bleeding between periods? |
| ___ | ___ Do you have heavy bleeding with your periods? |
| ___ | ___ Have you ever had discharge from your nipples? |
| ___ | ___ Do you have any children? If yes, how many? ___ |
| ___ | ___ Have you ever had a cesarean operation? |

MEN ONLY

- | | |
|-----|--|
| YES | NO |
| ___ | ___ Have you ever been treated for genital problems? |
| ___ | ___ Have you ever had prostate issues? |
| | ___ If yes, please describe: _____ |
| | _____ |