Accent Plastic & Reconstructive Surgery, PLLC

****

Patient Information

Please use black ink only

Name____(must have patients legal name)
Last First MI

Sex: (M / F) Date of Birth:______________ Marital Status (M / S / W / D) Social Security____________________

Referring Physician_________________________ Other Referral: Newspaper____ Radio_____ TV ____ Yellow Pages____

I was referred by another patient___________________________________

Mailing Address: ____ City: ___________State: _____ Zip:________

Phone #'s: Home ________________________ Work: ________________________ Cell:__________________________

The Best Way to Reach me is (Home / Work / Cell) Between __________(a.m. / p.m.) and __________(a.m. / p.m.)

Email address:____ Please send me information via email (Yes / No)

Employer: ______________________________ Employer Address (including zip): _______________________________

Nearest Relative not living with you: ____ Phone: _______________________

Responsible Party

Name____ Social Security ___________________________
Last First MI

Mailing Address: ____ City: ___________State: _____ Zip:________

Phone #'s: Home ____________________ Work: ________________________ Cell:__________________________

Employer: ______________________________ Employer Address (including zip): _______________________________

Occupation: _____________________________ Sex: (M / F) Date of Birth:__________

Relationship to Patient: _________________________ Parent's name (if not responsible party): _______________________

Parent's name (if patient is a minor): _____________________________________ Date of Birth: ____________________

WE MUST HAVE A COPY OF THE INSURANCE CARD, FRONT & BACK TO FILE INSURANCE

Notice of Privacy Practices

I, ______________________________, do hereby acknowledge receipt of the Notice of Privacy Practices of Accent Plastic & Reconstructive Surgery, PLLC.

Signature _____________________________________ **Date**__________

Disclosure of Personal Information

Accent Plastic & Reconstructive Surgery, PLLC will not discuss your personal health information with anyone except those allowed under federal and state law without your authorization. Please list the names and relationships of those whom you authorize us to discuss your personal health with:

Contact Name: ____Relationship: _______________ Phone: ____________

Contact Name: ____Relationship: _______________ Phone: ____________

Authorization signature: ____________________________________Date_________________

Accent Plastic & Reconstructive Surgery, PLLC

****

Medical History Form

Height: ______________________________

Weight: ______________________________

Age: ______________________________

Health History

Have you had or do you have any problems with:

Head…………………………………………… YES / NO
Eyes………………………………………… …. YES / NO
Ears, Nose Throat……………………………… YES / NO
Thyroid………………………………………… YES / NO
Lungs…………………………...……………… YES / NO
Heart…………………………………………… YES / NO
High Blood Pressure…………………………… YES / NO
Stroke……………………...…………………… YES / NO
Anemia……………………………..………… YES / NO
Blood Clots…………………………………..… YES / NO
Stomach…………………………………….….. YES / NO
Bowels……………………………………..…… YES / NO
Liver…………………………………………… YES / NO
Hepatitis……………………………………..… YES / NO
Jaundice……………………………...…… YES / NO
Muscles………………………………………… YES / NO
Bones…………………………………………… YES / NO
Arthritis………………………………………… YES / NO
Diabetes………………………………………… YES / NO
Cancer……………………………..………… YES / NO
HIV……………………………… ……………. YES / NO
History of Staff Infection ……………………… YES / NO

If yes, explain in detail:

____
____
____
____
____

Operations, Hospitalizations:

____
____
____
____

____

Current History

What Problems bring you to this office today?

____

What doctor do you see on a regular basis?

____

Doctor (s) to whom you want records sent?

____
____
____
____

Medications

Allergic to Medicine? Yes No

If yes, List medications:

____
____

List all medications you currently take:

____
____
____
____
____
____
____
____

Do you take aspirin? Yes No

Do you smoke? Yes No Packs per day ______

Do you drink alcohol? Yes No

Female only – Are you pregnant? Yes No
Last Menstrual Period? ______________

x ______________________________

Signature of Patient or Guardian