Plastic Surgical Arts — Jeffrey Colyer, M.D.

PATIENT INFORMATION

Today's Date: | Date of Birth: / /

Patient's Last Name: | First: | Middle: | ❑Mr. ❑Miss ❑Mrs. ❑Ms.

Street Address: | Social Security #: | Home Phone #:

City: | State: | ZIP Code:

Sex: ❑ M ❑ F | Age: | Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed | Race: | Cell Phone #:

Email Address: | Would you like to receive emails from our office regarding specials/products?: ❑ Yes ❑ No

Occupation: | Employer:

Employer's Address: | Work Phone #:

Reason for Consultation: | Primary Physician: | Phone #:

How did you hear about our office?: ❑ Family ❑ Friend ❑ Advertisement ❑ Physician ❑ Close to home/work ❑ Yellow Pages ❑ Internet ❑ Other _____

Referring Physician: | Phone #: | Date of Injury: / /

Where did accident occur?: ❑ Work ❑ Home ❑ Auto ❑ Other _____

IN CASE OF EMERGENCY

Contact Person: | Relationship:

Phone #: | Cell #: | Work #:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.) | Copay:

Primary Insurance Company: | Group #:

Policy #: | Policyholder: | Policyholder's SS #:

Relationship: | Date of Birth: | Employer:

Secondary Insurance Company: | Group #:

Policy #: | Policyholder: | Policyholder's SS #:

Relationship: | Date of Birth: | Employer:

PATIENT HISTORY

Please answer all the questions to the best of your knowledge. Your doctor, in his decisions regarding your care, will use the information provided by you.

Name:_____ Height: _____ Weight:_____

Do you or have you had any of the following:

- ❑ Arthritis
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding Disorder
- ❑ Blood Thinners
- ❑ Bronchitis/Pneumonia
- ❑ Cancer
- ❑ Chest Pain
- ❑ Chronic Hoarseness
- ❑ Chronic Skin Condition
- ❑ Chronic Sinus Problems
- ❑ Chronic Nasal Blockage
- ❑ Depression
- ❑ Diabetes
- ❑ Easy Bruising
- ❑ Eating Disorder
- ❑ Epilepsy
- ❑ Glaucoma/Blurry Vision
- ❑ Goiter
- ❑ Heart Problems
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV+ or AIDS
- ❑ Hormone Replacement
- ❑ Kidney Disease
- ❑ Latex Allergy
- ❑ Migraine
- ❑ Nervous Breakdown
- ❑ Paralysis of the Face
- ❑ Prednisone or Steroid Use
- ❑ Previous Cosmetic Surgery
- ❑ Fever Blisters
- ❑ Severe Dizziness or Headaches
- ❑ Schizophrenia or Psychosis
- ❑ Severe Dryness of the Eyes
- ❑ Shortness of Breath
- ❑ Stomach Ulcers
- ❑ Stroke

List any operations and the year:

_____

_____

_____

_____

_____

_____

_____

_____

If having breast surgery, have you every had problems with your breasts? ❑ Yes ❑ No

Do you have a history of breast cancer in your family? ❑ Yes ❑ No Who? _____

Date of your last mammogram: _____ Results: _____

List any other serious illnesses you have had: _____

_____

Do you take aspirin regularly? ❑ Yes ❑ No Have you had a blood transfusion? ❑ Yes ❑ No

Do you have nose bleeds? ❑ Yes ❑ No Do you regularly drink 6 or more cups of coffee per day? ❑ Yes ❑ No

Date of your last chest x-ray? _____ Date of last EKG? _____

Do you smoke? ❑ Yes ❑ No How much/week? _____

Do you drink alcohol? ❑ Yes ❑ No How much/week? _____

Do you take an herbal supplement? ❑ Yes ❑ No What kind? _____

List any medications you are currently taking and the dosage: _____

_____

Are you allergic to any medications? ❑ Yes ❑ No Which ones? _____

_____

Signature: _____ Date: _____

Insurance Authorization: The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize *Plastic Surgical Arts* to release any information required to process my claims.

Patient/Guardian signature: _____ *Date:* _____

Medicare Lifetime Consent: I request that payment of authorized Medicare benefits be made either to me or on my behalf to *Plastic Surgical Arts* for any services rendered by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services:

Patient/Guardian signature: _____ *Date:* _____