

Plastic and Reconstructive Surgery

DATE

PATIENT INFORMATION *(Please write information about the PATIENT here.)*

PATIENT'S NAME (Last, First, Middle Initial)		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	REFERRING PHYSICIAN	FAMILY PHYSICIAN
PATIENT'S ADDRESS		NEXT OF KIN		TELEPHONE ()
CITY	STATE	ZIP	EMPLOYER'S NAME	TELEPHONE ()
TELEPHONE ()	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	DATE OF BIRTH MO / DAY / YR	EMPLOYER'S ADDRESS
AGE	SOCIAL SECURITY NUMBER - -	EMPLOYMENT STATUS <input type="checkbox"/> Full Time <input type="checkbox"/> Retired <input type="checkbox"/> Part Time <input type="checkbox"/> Not Employed		STUDENT STATUS: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not a Student

Have you or a family member ever been a patient of this practice? Y N
Who? _____

Is your injury work related? Y N Date of accident _____
Is your injury due to an auto accident? Y N
Date of your auto accident _____



AMERICAN SOCIETY OF
PLASTIC AND RECONSTRUCTIVE
SURGEONS, INC.

Auto Insurance Information:

Insurance Company: _____
Claim Number: _____
Adjustors Name: _____ Telephone#: _____

INSURANCE INFORMATION *(Please write information about the PATIENT insurance here.)*

PRIMARY INSURANCE COMPANY NAME		
INSURANCE COMPANY'S CLAIMS OFFICE ADDRESS		
CITY	STATE	ZIP
INSURED'S ID NUMBER	GROUP / PLAN / POLICY NUMBER	

SECONDARY / SUPPLEMENTAL INSURANCE COMPANY NAME		
INSURANCE COMPANY'S CLAIMS OFFICE ADDRESS		
CITY	STATE	ZIP
INSURED'S ID NUMBER	GROUP / PLAN / POLICY NUMBER	

DO YOU HAVE MAJOR MEDICAL COVERAGE? YES NO

POLICYHOLDER INFORMATION *(Complete the information below if the PATIENT is NOT the POLICYHOLDER)*

PRIMARY POLICYHOLDER'S NAME (Last, First, Middle Initial)		DATE OF BIRTH MO / DAY / YR
PRIMARY POLICYHOLDER'S ADDRESS		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
CITY	STATE	ZIP
TELEPHONE ()	EMPLOYER'S NAME	
TELEPHONE ()	EMPLOYER'S ADDRESS	
CITY	STATE	ZIP
SOCIAL SECURITY NUMBER - -	RELATIONSHIP TO PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT OTHER	

SECONDARY / SUPPLEMENTAL POLICYHOLDER'S NAME (Last, First, Middle Initial)		DATE OF BIRTH MO / DAY / YR
SECONDARY / SUPPLEMENTAL POLICYHOLDER'S ADDRESS		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
CITY	STATE	ZIP
TELEPHONE ()	EMPLOYER'S NAME	
TELEPHONE ()	EMPLOYER'S ADDRESS	
CITY	STATE	ZIP
SOCIAL SECURITY NUMBER - -	RELATIONSHIP TO PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT OTHER	

Past Medical History

11-15-10

Please list all surgeries, illnesses, injuries and pregnancies with age of children:

Medications

Please list all medications you are taking, including Birth control pills, Vitamins, Aspirin and any other over the counter medications.

Drug: _____	Amount: _____	Reason: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____

General Health Questions

1.) Do you use Tobacco Products ? Yes: _____ No: _____

* Using Tobacco causes greater risks in skin loss & wound healing complications.

2.) Do you have Diabetes ? Yes: _____ No: _____

* Patients with Diabetes have many increased risks including: Cardiac, Infection, Poor Healing, Tissue Loss, Bleeding, etc.

3.) Are you allergic to Latex ? Yes: _____ No: _____

4.) Are you allergic to any Medications or Adhesives ? Yes: _____ No: _____

If you marked yes, please indicate medications and describe reaction: _____

5.) Have you ever had a bad reaction to General Anesthesia ? Yes: _____ No: _____

6.) Have you ever had a bad reaction to Local Anesthesia ? Yes: _____ No: _____

7.) Do you have High Blood Pressure ? Yes: _____ No: _____

8.) Do you have a Heart Condition ? Yes: _____ No: _____

9.) Do you bleed unusually easily from cuts or surgery ? Yes: _____ No: _____

10.) Do you form large Scars or Keloids (raised, thick scars) Yes: _____ No: _____

11.) Do you have frequent infections or boils ? Yes: _____ No: _____

Height: _____ Weight: _____ Any weight Change?: _____

* Have you seen another plastic surgeon about the same problem which brings you here ?

Yes: _____ No: _____ Comment: _____

** Signing the line below indicates, I give full permission to treat that above patient. I hereby authorize payment to be made directly to Northwest Plastic Surgery for any medical or surgical benefits that they may be entitled to under my Medical-Surgical Plan: If my insurance company determines the services rendered are not medically necessary, cosmetic, or otherwise non-covered under my policy I agree to be responsible for the payment of the services. I understand there may be additional charges including: Lab, Pathology, x-ray, and hospital charges included with my treatment. I also give permission for the use of any photograph or x-ray in this case for medical education purposes or seminars. I agree that I am responsible for all charges for medical/legal work including reports, depositions, and testimony that the doctor is required to perform in conjunction with the patients care. These charges my be attached to any settlement monies won in conjunction with this case.

Witness: _____

Signature of Policy Holder

Date: _____