DETROIT PLASTIC SURGERY

Patient Information

◯ M ◯ F Marital Status ____________ Birthdate ____________ Referred By ____________

Last Name ____________ First Name ____________ Middle ____________ SS# ____________

Address ____________ Apt # ____________ City ____________ State ____ Zip ________

Home # ____________ Work # ____________ Cell # ____________ Preferred # to Call ________

Email Address ____

Race________ Ethnicity__________ Preferred Language______________

Employer Name ____________ Address ____________ City ____________ State ____ Zip ________

Pharmacy Name______________ Address ______________ City____________

Pharmacy Phone #__________

Patient Record of Disclosure

Home Phone: ◯ OK to leave message with detailed information ◯ Leave message with call-back number only

Work Phone: ◯ OK to leave message with detailed information ◯ Leave message with call-back number only

Cell Phone: ◯ OK to leave message with detailed information ◯ Leave message with call-back number only

Emergency Contact: ______________________________

Written Communication: ◯ OK to mail to home address ◯ OK to mail to work /office ◯ OK to fax to this number

Other ______________________________

Primary Care Physician: ____

Name Phone Address City State Zip Code

Referring Physician: ____

Name Phone Address City State Zip Code

Is this appointment work or auto related? If yes, Claim # __________ Ins. Co.__________ Phone __________

Primary Insurance

Name of Insurance ____________ Referral Needed ◯ Yes ◯ No CoPay __________

____

Policy holder's Last Name First Name Middle Date of Birth SS #

____

Insurance Contract # Group # Phone # AddressCity State Zip

____

Subscriber's Address (if different than patient) City State Zip Phone #

Secondary Insurance

Name of Insurance Referral Needed ◯ Yes ◯ No CoPay __________

____

Policy holder's Last Name First Name Middle Date of Birth SS #

____

Insurance Contract # Group # Phone # AddressCity State Zip

____

Subscriber's Address (if different than patient) City State Zip Phone #

Authorization and Release

I certify that I have read and understood the above information to the best of my knowledge. I authorize the release of all medical records to health professionals and my insurance company. I acknowledge full financial responsibility for services rendered by Detroit Plastic Surgery. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I authorize and request that insurance payments be made directly to Detroit Plastic Surgery. I have read and fully understand the above consent for treatment and financial responsibility, release of medical information and insurance authorization. I understand I have a right to review the HIPPA Notice of Privacy Practice Brochure.

Signature:______________________ Date: __________ Guardian's Name ______________________
(if patient is a minor)

Patient Name:___________________ **Height:**_____ **Weight:**_____

Martial Status: _____

Father: Living _____ **Deceased** _____ **Mother: Living** _____ **Deceased** _____

	Yes	No		Yes	No
Do you or have you ever smoked? If yes , years?____			Number packs/per day_______ Last Smoked?________		
Do you drink alcoholic beverages on a weekly basis			Yes, How much?_____________		
Are you taking any controlled substances currently			Yes, Name ______________		
Do you use Marijuana __ Cocaine __ Heroin__ other___			If yes, how often_____ When was the last time used ____		
Do you have Amedical Marijuana Card					
Do you have chronic pain			**If yes, Mild**____ **Moderate** ____ **Severe**___		
Do you have or have you ever had any of the following?	**Yes**	**No**		**Yes**	**No**
Diabetes			Do you get cold sore/fever blisters		
Sleep Apnea			History of Bleeding or Bruising		
Pacemaker/ICD			Excess Bleeding from Surgery		
Do you have an Advance Care Directive			Ultrasound of the Heart (Echo)		
Breast Cancer			An exam by a cardiologist (heart doctor)		
Had a mammogram done. If yes, Year _____			Heart Catheterization		
Have you had Flu Vaccine			Irregulart Heart Beat, Palpitations/A-Fib		
Have you had Pneumonia Vaccine			Blood Transfusion		
Any loose or chipped teeth			Do you get blood clots in your legs_____ and/or lungs____		
Caps/Bridges/Dentures/Root Canal/Crowns			Hearing Aid		
Temporal Mandibular Joint Disease			Glasses/ Contacts		
History of Asthma			Heart Failure		
Tuberculosis			Heart Valve DisorderBypass/Stents		
High Blood Pressure			Do you take Pre-Dental Antibiotics		
Chest Pain			Stomach Ulcer		
Have you gained 10-15 pound in the last year?			Kidney Disorder		
Do you have excessive daytime sleepiness?			Thyroid Disorder		
Epilepsy/Seizures			Liver Disease, Jaundice, Hepatitis		
History of Anemia			Multiple Scleroisis or Polio		
Stroke			Head Injury		
Sickle-Cell Anemia/Trait			Scoliosis		
Rheumatic Fever			Infections diseases or conditions effecting immune system		
			If yes,Please circle AIDS, HIV infection, radiotherapy,chemotherapy		

Other medical conditions not listed: ______

List Allergies to medication; **LATEX ALLERGY?:**__________

List all medications you are taking and dosage

Medication continued

List all previous Surgeries : Year

Reason

X ______________________

Signature of Patient, Parent, or Legal Guardian

X ______________________

Date