Patient Intake Form

Name:_____ Date of Birth __ __ / __ __ / __ __ __ __
(first) (middle) (last) (month) (day) (year)

Gender: Male Female Marital Status: Single Married Divorced Widowed Social Security: __ __ __ -- __ __ --__ __ __ __

Address:_____City:_____ State: _____Zip: _____

Phone Number(s) Home: __ __ __ -- __ __ __--__ __ __ __ Mobile : __ __ __ -- __ __ __--__ __ __ __ Work: __ __ __ -- __ __ __--__ __ __ __

Email Address:_____ Preferred Contact: Phone-Mobile Phone-Home Email Text

Employer:_____ Employer Phone: __ __ __ -- __ __ __--__ __ __ __

Employment Status:_____ Occupation:_____ Currently Enrolled in School: Yes No

Emergency Contacts Information and Relationship to Patient

Name:_____Relationship:_____Phone: __ __ __ -- __ __ __--__ __ __ __

Name:_____Relationship:_____ Phone: __ __ __ -- __ __ __--__ __ __ __

Has any family member or friend been treated at our practice? Yes No if **yes,**_____
(Name and relation to patient)

Referring Physician Information:

Physician Name:_____ Specialty:_____ Office Name:_____

Address:_____ Phone: __ __ __ -- __ __ __--__ __ __ __

Primary Care Physician Information (if different than referring physician):

Physician Name:_____ Specialty:_____ Office Name:_____

Address:_____ Phone: __ __ __ -- __ __ __--__ __ __ __

Does your insurance require a referral? Yes No ; if **yes,** please provide the referral to the receptionist

Pharmacy Information

Pharmacy Name:_____ Phone: __ __ __ -- __ __ __--__ __ __ __

Pharmacy Address:_____

Guarantor if not the patient (financially responsible party for minor or incapacitated adult):

Name:_____ Date of Birth __ __ / __ __ / __ __ __ __ Relationship to patient :_____

Address:_____ City:_____ State: _____Zip: _____

	Primary Insurance	**Secondary Insurance**
Name of Insurance		
Policy Holder Name and Date of Birth		
Policy Holder Relationship to Patient		
Policy/Member ID Number		
Group/Plan Number		

In your own words, briefly describe your reason for visit today: _____

_____

Have you ever seen a physician regarding your reason for visit today? Yes No if **yes,** when; _____

Current state of health: **Good** **Fair** **Bad** ;if **Fair** or **Bad**, please explain why:_____

Date of last physical: __ __ / __ __ Date of last EKG: __ __ / __ __ Date of last Chest X-Ray: __ __ / __ __
(month) (year) (month) (year) (month) (year)

Height: ___ ft _____ inches Weight: _____lbs.

In the past year I have; LOST GAINED MAINTAINED my weight. If, *LOST* or *GAINED* how much? _____ lbs.

Are you pregnant or breastfeeding? Yes No Pregnancies: _____ Children: _____

Last Menstrual Period: __ __ / __ __ /_____ Last Mammogram: __ __ / __ __
(month) (day) (year) (month) (year)

Please Indicate Consumption of the following

How Much Caffeine do you Consume DAILY; **Coffee**:_____ /cups per day **Tea**:_____ /cups per day

Please describe your alcohol intake: **None** **Occasionally** **Socially** **Frequently**

Do you smoke? **Never** **Former;** I quit _____ Months/Years. **Currently;** _____ Packs per week.

Does anyone else in your household smoke? **Yes** **No**

Are you taking any of the following?
(Please check)

☐ Aspirin	☐ Motrin	☐ Coumadin	☐ Herbal Supplements
☐ Plavix	☐ Celebrex	☐ Birth Control	☐ Insulin
☐ Vitamins	☐ Hormone Supplement/Replacement		☐ Retin A? (Last Dose_____)
☐ Steroids Cortisone or ACTH (How Long?_____)			☐ Accutane?(Last Dose_____)

Do you have a personal health history **and/or** currently undergoing treatment for the following?
(Please check)

☐ Asthma	☐ Diabetes	☐ Hypertension	☐ Autoimmune Disease
☐ Kidney Disease	☐ Ulcers	☐ Stroke	☐ Bleeding/Clotting Disorder
☐ Thyroid Problems	☐ Anxiety	☐ Depression	☐ Heart/Attack Disease
☐ Gastro Disease	☐ Hepatitis	☐ Cancer	☐ Psychiatric Illness

Additional health conditions and/or prescription and non-prescription medications you are taking: _____

_____

Do you use any topical medications? Yes No

If yes, please list all topical medications _____

Drug sensitivity and allergies (describe): _____

Do you have any skin allergies or sensitivities? Yes No ; If yes, please explain _____

Pertinent Operative History

Have you ever reacted badly to anesthesia or being put to sleep for surgery?	Yes	No
Has anyone in your family reacted badly to anesthesia or being put to sleep?	Yes	No
Have you reacted badly to Local Anesthesia (i.e. Novocain, Lidocaine)?	Yes	No
Have you ever suffered from Scarlet or Rheumatic Fever?	Yes	No
Do you bruise or bleed easily?	Yes	No
Do you form large scars or Keloid from surgery or when you cut yourself?	Yes	No
Does your religion forbid blood transfusions?	Yes	No
Do you have frequent infections or boils?	Yes	No
Do you have skin conditions, rashes, hives, and eczema?	Yes	No

Past Surgical History (Type and Year)

_____

_____

_____

Family Health History

	Age:	State of Health :
Mother:	_____	_____
Father:	_____	_____
Siblings:	_____	_____
	_____	_____
	_____	_____

Medical Acknowledgements

Please INITIAL that you have been informed about and accept each policy.

____The healthcare professionals participating in my care will rely on my medical history and other information obtained from me, my family or others having knowledge about me, in determining whether to recommend or perform procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions.

____The practice of medicine is not an exact science. No guarantees will be made to me as the result of any examination.

____If a health care worker is exposed to my blood as a result of care provided at this practice, my blood may be tested.

By signing below, I acknowledge and agree that I have read or had these policies read to me and I understand and agree to its contents.

PATIENT / REPRESENTATIVE DATE

Financial Policy Acknowledgements

Please INITIAL that you have been informed about and accept each policy.

____The cost of surgery involves several charges for the services provided. Depending on whether the cost of surgery is covered by an insurance plan, you will be responsible for necessary co-payments, deductibles, and charges not covered.

____The fees charged for this procedure do not include any potential future costs for additional procedures that you elect to have or require to revise, optimize, or complete your outcome.

____I understand that with cosmetic surgery, I am responsible for the surgical fees quoted to me, as well as pre-operative exams, laboratory testing fees, X-ray, and pathology fees.

____Surgical Outpatient Facilities; often have rules requiring certain tissue/implants removed during surgery MUST be sent for evaluation which may result in additional fees.

____I understand that there will be a non-refundable fee for booking and scheduling my surgery, which is a part of the overall surgical fee.

____ Should I cancel my surgery without an approved medically acceptable reason, submitted in writing and acceptable to the practice at its discretion, within **TWO** weeks of the scheduled surgery, this fee is forfeited. While this may appear to be a charge for services which were not provided, this fee is necessary to reserve time in the OR and in the practice, which are done when I schedule.

By signing below, I acknowledge and agree that I have read or had these policies read to me and I understand and agree to its contents.

PATIENT / REPRESENTATIVE DATE

Photography and recording acknowledgements

Please INITIAL that you have been informed about and accept each policy.

___ Providers may take photographs or videotapes of patients for medical documentation or identification. Photographs and related information may be published in professional journals or medical books, or used for any similar purpose in the interest of medical education, knowledge or research; provided, however, that in any such publication or use, I will not be identifiable. No protected health information will be released without my consent.

By signing below, I acknowledge and agree that I have read or had these policies read to me and I understand and agree to its contents. Nothing in this agreement supersedes any other policies I may have signed or hereafter sign, including the Patient Financial Responsibility Agreement, Legal Assignment Consent, and other Surgical or Anesthesia Consents.

PATIENT / REPRESENTATIVE DATE

Notice of Privacy Practices Consent

(please reference document provided)

By signing below, I attest to the fact that I have received and read the packet on Notice of Privacy Practices from Lexington Plastic Surgeons.

PATIENT / REPRESENTATIVE DATE