

PLEASE PRINT CLEARLY

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(first) (middle initial) (last)

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext. \_\_\_\_\_

Patient's S.S. #: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_

Marital Status: (S) (M) (D) (W) Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ S.S.# \_\_\_\_\_

Spouse's Work Phone: \_\_\_\_\_ Ext. \_\_\_\_\_

Name of nearest relative NOT living with you: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Relationship: \_\_\_\_\_

**If Patient is under 18 yrs. Of age, Parent/Guardian Name:** \_\_\_\_\_

Parent/Guardian D.O.B. \_\_\_\_\_ S.S.#: \_\_\_\_\_

Parent/Guardian Work Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

## **INSURANCE INFORMATION**

*(Please fill out if you are NOT the Primary Card Holder and you plan on using Insurance)*

**PRIMARY INSURANCE COMPANY:** \_\_\_\_\_

Policy Holder: \_\_\_\_\_

D.O.B. \_\_\_\_\_ S.S. #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**SECONDARY INSURANCE COMPANY:** \_\_\_\_\_

Policy Holder: \_\_\_\_\_

D.O.B. \_\_\_\_\_ S.S. #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

\*We do not file with Insurance for any Cosmetic Procedures...Breast Augmentations, Liposuction, Abdominoplasty, Facelifts, Gynecomastia, etc. and any procedures desired from the result of extreme weight-loss.\*

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**Reason for Consultation:** \_\_\_\_\_  
(Type of procedure(s) of interest *or* type of injury, please be specific)

Was this due to an accident: YES NO If yes, please explain what happened: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Place of Injury: (circle one) Home Work Auto Other

If other, please specify: \_\_\_\_\_

Referred by: \_\_\_\_\_  
(Must have Physician's name for Medicare and Medicaid Patients)

Primary Care Physician: \_\_\_\_\_  
(Must have Physician's name for HMO Patients)

List all medications you are currently taking (such as vitamins, birth control, aspirin): \_\_\_\_\_

List any drugs that you are allergic to: \_\_\_\_\_

**Does YOUR personal medical history include any of the following?**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Hepatitis, Type _____ | <input type="checkbox"/> Anemia           | <input type="checkbox"/> Keloids            |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Thyroid Condition     | <input type="checkbox"/> Eczema           | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Currently Pregnant    | <input type="checkbox"/> Sun Sensitivity  | <input type="checkbox"/> Emotional Disorder |
| <input type="checkbox"/> Emphysema   | <input type="checkbox"/> Cystic Breasts        | <input type="checkbox"/> Cold Sensitivity | <input type="checkbox"/> Poor Wound Healing |
| <input type="checkbox"/> Tuberculosis  | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Hives            | <input type="checkbox"/> Glasses / Contacts |
| <input type="checkbox"/> Lung Disease  | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Sinus Problems   |   |
| <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> Excessive Bleeding    |   |   |
| <input type="checkbox"/> Smoking (# of cigarettes a day _____ for # of years: _____) |  |   |   |

List any medical problems not listed above: \_\_\_\_\_

List any prior surgery (what & when): \_\_\_\_\_