



Name: _____ Date: _____ Height: _____ Weight: _____

Reason for Consultation: _____

What procedure(s) are you interested in? _____

HABITS: Smoking? Yes or No If Yes, give amount per day _____
Alcohol? No Occasional/Social Daily If Daily, give amount per day _____
Exercise? Yes or No If Yes, how many times per week? _____ Minutes per workout? _____
Coffee? Yes or No If Yes, how many cups per day? _____

Drug Allergies (if any): _____ Latex Allergy?: Yes or No

Medications: 1. _____ 2. _____ 3. _____ 4. _____
5. _____ 6. _____ 7. _____
8. _____

If more than eight, please provide list.

Past Surgical History (with approximate year): _____

Medical History/Review Of Systems: Have you ever had any of the following?

Asthma	Y or N	Blood Clots	Y or N	Abnormal Bleeding	Y or N	Diabetes	Y or N
Hepatitis	Y or N	Sleep Apnea	Y or N	High Blood Pressure	Y or N	Anemia	Y or N
Chest Pain	Y or N	Heart Attack	Y or N	Heart Disease	Y or N	Lung Disease	Y or N
Seizures	Y or N	Short of Breath	Y or N	Fainting/Dizziness	Y or N	Arthritis	Y or N
HIV	Y or N	Acid Reflux	Y or N	Cancer	Y or N	Transfusion	Y or N

Any Personal or Family History of Adverse Reactions to Anesthesia? Y or N If yes, please describe: _____

FOR WOMEN ONLY: Number of Pregnancies: _____ Number of Children: _____ Breast Feed? Y or N
If Yes, how long? _____ On Birth Control? Y or N Last Menstrual Period: _____
Date of Last Mammogram: _____ Results: _____ Current Bra Size: _____

THIS IS A CONFIDENTIAL REPORT OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HEREIN WILL NOT BE RELEASED TO ANY PERSONS EXCEPT WHEN YOU HAVE AUTHORIZED US TO DO SO.



PATIENT INFORMATION

Name: _____ Home Phone: _____ Cell Phone: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Occupation: _____ Employer: _____ Work Phone: _____
Sex: M F Marital Status: S M D W Email Address: _____
Social Security #: _____ Date Of Birth: _____ Age: _____
Spouse's Name: _____ Occupation: _____ Employer: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
How did you hear about us? Physician Referral Dr. _____ Family Member/Friend _____
Internet About Town Magazine Gold's Gym Phone Book Other _____

RESPONSIBLE PARTY INFORMATION

Name of Responsible Party: _____ Home Phone: _____ Cell Phone: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Occupation: _____ Employer: _____ Work Phone: _____
Relationship to Patient: _____

INSURANCE COMPANY:

Name of Insurance Co.: _____ Contract #: _____ Group #: _____
Name of Insured as it Appears on Card: _____ Date of Birth: _____ SS#: _____
Name of Secondary Insurance Co.: _____ Contract#: _____ Group#: _____
Name of Insured as it Appears on Card: _____ Date of Birth: _____ SS#: _____

I hereby authorize Plastic Surgery Specialists to release any information acquired in my examination or treatment to any insurer, government agency providing benefits, or to anyone for charges. I also, hereby, assign to and authorize payment to Plastic Surgery Specialists of all benefits payable under the terms of any insurance policy listed. I realize the insurance, workman's compensation, and/or liability claims may not pay the entire bill, and I agree to pay the difference of the entire bill if necessary. In the event the account is not paid in full within 90 days I also agree to pay costs of collection, including attorney's fee and waive my exemption under the constitution and laws of the state of Alabama. I understand that it is my obligation to my copayment at the time services are rendered (as stated in my signed contract with my insurance company). I understand that it is the policy of Plastic Surgery Specialists to collect and all deductibles or outstanding account balance before surgical procedures will be performed. Plastic Surgery Specialists participates with the Worthless Check Unit of the City of Birmingham and does prosecute for bad checks written to our company. All court costs are the responsibility of the patient and/or check writer.

PATIENT'S SIGNATURE: _____ DATE: _____

RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

(IF PATIENT IS A MINOR)