GUPTA
Plastic Surgery

PATIENT INFORMATION:

Mr./Mrs./Ms./Miss/Dr.
Name (Last Name, First, MI):_____ Sex: Male Female
Address:_____ City, State, ZIP:_____
Home Phone: (_____)_____ Cell Phone: (_____)_____
Date of Birth:_____ SS#:_____ Email:_____

What would you like us to call you? Do you have a nickname?_____
What phone numbers may we call you at? HOME CELL WORK ANY
May we leave a message on an answering machine or with a family member? YES NO
May we email or mail you information on services offered by our office? YES NO
(Botox specials, Skin care products, etc.)

REFERRED BY:_____ ***PRIMARY CARE PHYSICIAN:***_____

MARITAL STATUS (please circle): SINGLE MARRIED DIVORCED SEPARATED WIDOWED

SPOUSE:
Name:_____ Date of Birth:_____ SS#:_____
Home Phone: (_____)_____ Cell Phone: (_____)_____

PATIENT EMPLOYMENT INFORMATION:
Employer:_____ Occupation:_____
Address:_____ Phone: (_____)_____

RESPONSIBLE PARTY'S NAME:_____ Phone: (_____)_____

PRIMARY INSURANCE:
Insurance Carrier:_____ Subscriber Name:_____
Address:_____ Policy ID#:_____
City, State, ZIP:_____ Group#:_____
Phone: (_____)_____

SECONDARY INSURANCE:
Insurance Carrier:_____ Subscriber Name:_____
Address:_____ Policy ID#:_____
City, State, ZIP:_____ Group#:_____
Phone: (_____)_____

EMERGENCY CONTACT INFORMATION (a relative or friend not living with you):
Name:_____ Relationship:_____
Address:_____ City, State, ZIP:_____
Phone: (_____)_____

I hereby irrevocably assign and transfer all payment of benefits for any and all services rendered by Abhay Gupta, M.D. Inc. to be made directly payable to Abhay Gupta, M.D. Inc or Gupta Plastic Surgery regardless of my insurance benefits, if any, and agree to allow a photocopy of my signature to be used to file insurance. I understand that each patient or responsible party is financially responsible for all services rendered. In the instance of any dispute with my insurance company regarding payment, I authorize Abhay Gupta, M.D., Inc. to act on my behalf. While the Billing Office is pleased to assist in the preparation and submission of insurance forms, the obligation for payment remains that of the responsible party. In the case of an accepted Worker's Compensation injury, it is understood that the patient is not financially responsible. I also authorize Abhay Gupta, M.D., F.A.C.S. to render medical treatment.

_____ _____
PATIENT SIGNATURE RESPONSIBLE PARTY SIGNATURE

_____ _____
DATE DATE

GUPTA Plastic Surgery

MEDICAL QUESTIONNAIRE:

CHIEF COMPLAINT / REASON FOR VISIT: _____

OTHER DOCTORS YOU HAVE SEEN FOR THIS CONDITION:_____

SERIOUS MEDICAL PROBLEMS: (please list)

_____

CURRENT MEDICATIONS:

NAME	DOSE	HOW OFTEN	DATE LAST TAKEN
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

DO YOU TAKE ASPIRIN ON A REGULAR BASIS? NO YES
DO YOU HAVE A PACEMAKER? NO YES

ALLERGIES:

Are you allergic to any medication? NO YES If yes, what medication?_____
What type of reaction do you have? (Please circle)
FLUSHING RASH DIZZINESS HIVES SWELLING LOSS OF CONSCIOUSNESS OTHER:_____

Do medications have an unusual effect on you? NO YES If yes, what effect?_____

Are you allergic to adhesive tape? NO YES
Are you allergic to iodine? NO YES
Please list any other allergies:_____

HABITS:

Do you have alcoholic beverages more than 2-3 times per week? NO YES If yes, how many per day?_____
Do you smoke? NO YES Please circle: Cigarettes Cigars Pipe If yes, how many per day?_____

FAMILY HISTORY:

FAMILY MEMBER	AGE (if alive)	AGE (if deceased)	CAUSE OF DEATH	SERIOUS ILLNESS (Heart, Diabetes, Cancer)
Father				
Mother				
Bro/Sis/Son/Daughter				
Bro/Sis/Son/Daughter				
Bro/Sis/Son/Daughter				

Has anyone in your family had a tendency to bleed extensively? NO YES
Has anyone in your family had an unusual reaction to anesthesia? NO YES
Has anyone in your family had unexplained fevers following surgery? NO YES
Have you ever had a blood transfusion? NO YES
Do you have any metal in your body? NO YES If yes, where?_____

GUPTA Plastic Surgery

MEDICAL QUESTIONNAIRE:

PAST SURGICAL HISTORY:

	DATE	OPERATION	SURGEON	HOSPITAL
1.				
2.				
3.				
4.				
5.				
6.				

PAST MEDICAL HISTORY: ***Have you ever had any of the following:***

Heart Disease	NO	YES	Heart Attack	NO	YES	Cancer	NO	YES
Arthritis	NO	YES	Glaucoma	NO	YES	Leukemia	NO	YES
Rheumatic Fever	NO	YES	Asthma	NO	YES	Mitral Valve Prolapse	NO	YES
Anemia	NO	YES	AIDS or HIV+	NO	YES	High Blood Pressure	NO	YES
Tuberculosis	NO	YES	Stroke	NO	YES	Drug Addiction	NO	YES
Diabetes	NO	YES	Hepatitis	NO	YES	Emphysema	NO	YES

PLEASE ELABORATE ON ANY "YES" ANSWER:_____

_____

_____

REVIEW OF SYSTEMS: ***Do you now or have you had within the past year any of the following:***

Weight Change	NO	YES	Chest pain	NO	YES	Stomach Ulcer	NO	YES
Obesity	NO	YES	Shortness of Breath	NO	YES	Kidney Disease	NO	YES
Depression	NO	YES	Fainting Spells	NO	YES	Thyroid Disease	NO	YES
Other Mental Disease	NO	YES	Rapid Heartbeat	NO	YES	Jaundice	NO	YES
Suicidal Tendencies	NO	YES	Circulatory Disease	NO	YES	Swollen Lymph Nodes	NO	YES
Frequent Headaches	NO	YES	Phlebitis	NO	YES	Urinary Infection	NO	YES
Easy Bleeding	NO	YES	Lung Disease	NO	YES	Chronic Diarrhea	NO	YES
Easy Bruising	NO	YES	Bronchitis	NO	YES	Joint or Muscle Pain	NO	YES
Skin Rash	NO	YES	Chronic Cough	NO	YES	Nerve or Muscle Disease	NO	YES
Dry Eyes	NO	YES	Ear Condition	NO	YES	Throat Condition	NO	YES

PLEASE ELABORATE ON ANY "YES" ANSWER:_____

_____

_____

PLEASE NOTE: MEDICAL DOCTORS ARE LICENSED AND REGULATED BY THE MEDICAL BOARD OF CALIFORNIA (800) 633-2322; www.mbc.ca.gov

WOMEN ONLY:

Age period began:_____ Number of pregnancies / deliveries: _____ Did you breast feed? NO YES

Date of last mammogram:_____ Do you perform regular breast self-examinations? NO YES

Do you have a breast lump or any discharge? NO YES If yes, please explain_____

Do you take oral contraceptives? NO YES

IS THERE ANY POSSIBILITY OF YOU BEING PREGNANT AT THIS TIME? NO YES

I verify that the above information is true and accurate to the best of my knowledge.

_____ _____

Patient Signature or Parent/Guardian if Patient is a Minor Date