

Lane F. Smith, MD
PATIENT HISTORY / INFORMATION



PATIENT INFORMATION

Date		Patient Name: Last		First	Middle
Address				City	State
Zip	Sex	Age	Birth date	Status <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
Social Security #		Employed By			Home Phone
Referred By		Nearest Relative or Friend not Living with You		Contact Phone	Your Cell Phone
					Business Phone

RESPONSIBLE PARTY

Name: Last		First	Relationship to Patient	Phone
Home Address		City	State	Zip
Social Security #	Occupation	Employed By		Business Phone
Business Address		City	State	Zip
Spouse's Name	Employer			Phone

Most insurance carriers do not cover cosmetic procedures. You only need to complete this section if your consultation is for an insurance covered procedure.

PRIMARY INSURANCE INFORMATION

Insurance Company <input type="checkbox"/> Health	Policyholder's Name	Policyholder's Date of Birth	Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Insurance Co. Address	City	State	Zip	Ins. Phone
Social Security # or ID #	Group #	Medicare #	Accident Claim #	

SECONDARY / INDUSTRIAL INSURANCE INFORMATION

Insurance Company <input type="checkbox"/> Health	Policyholder's Name	Policyholder's Date of Birth	Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Insurance Co. Address	City	State	Zip	Ins. Phone
Social Security # or ID #	Group #	Medicare #	Accident Claim #	

REASON FOR VISIT

Explain Problems, Symptoms, Expectations, Etc.

If Accident: How?	When?	Where?
-------------------	-------	--------

TODAY I WILL PAY BY

Cash
 Check
 Credit Card (We Accept VISA, MasterCard, Discover and American Express)

MEDICAL HISTORY

Physician's Name	Address	Phone
Date of Your Last Physical Examination	Height	Weight

PLEASE CHECK ONE:

	YES:	NO:
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>
Are you now, or have you been under the care of a physician during the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
If so, for what reason?		
Are you sensitive (allergic) to penicillin, novocaine, or any other drugs?	<input type="checkbox"/>	<input type="checkbox"/>
If so, give the name of each		
Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any implants such as an artificial heart valve or hip prostheses?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty breathing through your nose?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dry eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced frequent corneal abrasions (scratches over the surface of the eye) ?	<input type="checkbox"/>	<input type="checkbox"/>
Have you experience excessive tearing of the eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a detached retina?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have allergies (dust, pollen, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had previous blood transfusions?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
Are you now, or have you been under the care of a physician during the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke? If so, how many packs a day?	<input type="checkbox"/>	<input type="checkbox"/>
Please list previous surgeries		

Please list all medicines, drugs or pills that you are now taking, or have taken within the past year. Please include birth control pills and over-the-counter medications such as aspirin, Bufferin, Advil, Motrin, etc.

Do you have, or have you ever had, any of the following?

	YES:	NO:		YES:	NO:		YES:	NO:
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Scarring	<input type="checkbox"/>	<input type="checkbox"/>
Fainting.....	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Recent Cold or Cough.....	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Ankle Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Cancer or Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive.....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea.....	<input type="checkbox"/>	<input type="checkbox"/>
Family History of Bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Facial Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Jaw / Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>
Family History of Blood Clots.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>	IMPORTANT: Please let us know if you suspect pregnancy during any part of our treatment.		
History of Back Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Immune Deficiencies.....	<input type="checkbox"/>	<input type="checkbox"/>			
			Changes in Vision	<input type="checkbox"/>	<input type="checkbox"/>			

HOW DID YOU FIND US?

Please check all the places you have heard of us

<input type="checkbox"/> Referral Name	<input type="checkbox"/> Physician Name	<input type="checkbox"/> Telephone Book, Specify	<input type="checkbox"/> Yellow Pages Ad	<input type="checkbox"/> Information Guide (front)
<input type="checkbox"/> Mailer	<input type="checkbox"/> Newspaper Ad	<input type="checkbox"/> Website	<input type="checkbox"/> Salt Lake Living Magazine	<input type="checkbox"/> Salt Lake Magazine
<input type="checkbox"/> Other Publication, Specify _____				

What helped you make your final decision to set up an appointment?