



**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)



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: \_\_\_\_\_