RSJ Plastic Surgery

PATIENT REGISTRATION INFORMATION

Patient : Last Name : ______________________ First Name : ______________________ Mid Name : ________________

I prefer to be called: ____ Birthday: ______/______/______ Age: ________

Sex: ☐ Male ☐ Female SSN: ______-______-______ Driver's license #: ______________________________

Marital status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced/Separated ☐ Widowed

Home address: ________________________ Apt. #: ______ City: ______________________ State: ______ Zip: ________

Home phone #: (______) - ______ ______ Cell #: (______) - ______ - ______ Work #: (______) - ______ - ______ Ext: ______

Email address: ____

Where & when are best times to reach you? ____

How did you hear about us? ____________________ Whom may we thank for referring you? ____________________

Person responsible for account: ____

Other family members seen by us: ____

Employer Details-

Employer: ____

Employer address: ______________________ Apt. #: ______ City: ______________________ State: ______ Zip: ________

Occupation: ____ How long there? ______________________

Spouse Information -

His / Her name: ____ Cell #: (______) - ______ - ______

Employer: ____ Work #: (______) - ______ - ______ Ext: ______

Home address: ________________________ Apt. #: ______ City: ______________________ State: ______ Zip: ________

SSN: ______-______-______ Birthday: ______/______/______ Driver's license number: ______________________________

Emergency Contact Details (Relative or friend not living with you)-

His / Her name: ____ Relationship: ______________________

Home Phone #: (______) - ______ - ______ Work #: (______) - ______ - ______ Ext: ______

INSURANCE INFORMATION

Insurance Co.: ______________________________

Insurance Co. Address: ______________________________

City: ______________________ State: ________ Zip: ________

Insurance Co. Phone #:(_____) -_______ - ________

Group# (Plan, Local or Policy #): ______________________________

Insured's name: ______________________________

Relationship: ______________________________

Insured's Birthday: _____/_____/______ SSN: _____-_____-_____

Insured's employer: ______________________________

Employer Address: ______________________________

City: ______________________ State: ________ Zip: ________

Insurance Co.: ______________________________

Insurance Co. Address: ______________________________

City: ______________________ State: ________ Zip: ________

Insurance Co. Phone # (______) -_______ - ________

Group# (Plan, Local or Policy #): ______________________________

Insured's name: ______________________________

Relationship: ______________________________

Insured's Birthday: ______/______/______ SSN: _____-_____-_____

Insured's employer: ______________________________

Employer Address: ______________________________

City: ______________________ State: ________ Zip: ________

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ______________________________

Telephonec#: (_______) - _______ - _______ Date: ________/________/________

Your current physical health is : ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Explain : ______________________________

Is there a history of **deep venous thrombosis (D.V.T.)**? ☐ Yes ☐ No

Explain : ______________________________

Is there a history of **pulmonary embolism (P.E.)**? ☐ Yes ☐ No

Explain : ______________________________

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / Over-the-counter drugs? ☐ Yes ☐ No

Explain : ______________________________

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

For Women : Are you using a prescribed method of birth control? ☐ Yes ☐ No

For Women : Are you pregnant? Week # : ___________ ☐ Yes ☐ No

For Women : Are you nursing? ☐ Yes ☐ No

For Women : Have you ever had a mammogram? ☐ Yes ☐ No

For Women : When was your last menstrual cycle? ______________________________

For Women : In your life, how many pregnancies have you had? ______________________________

For Women : How many children do you have? ______________________________

Have you ever had any of the following diseases or medical problems?

- [ ] Abnormal Bleeding / Hemophilia
- [ ] AIDS / HIV related complex
- [ ] Alcohol / Drug abuse
- [ ] Allergies or Hives
- [ ] Anemia
- [ ] Angina pectoris
- [ ] Arthritis
- [ ] Artifical prosthesis
- [ ] Artificial bones / Joints / Valves
- [ ] Asthma
- [ ] Blood disease
- [ ] Blood transfusion
- [ ] Cerebral palsy
- [ ] Chemotherapy (Center, leukemia)
- [ ] Chicken pox
- [ ] Colitis
- [ ] Congenital heart defect
- [ ] Congenital heart disease
- [ ] Diabetes
- [ ] Difficulty breathing
- [ ] Drug addiction
- [ ] COPD / Emphysema
- [ ] Epilepsy / seizures
- [ ] Excessive bleeding
- [ ] Fainting spells / seizures
- [ ] Frequent headaches
- [ ] Glaucoma
- [ ] Hay fever
- [ ] Head injuries
- [ ] Heart attack / Surgery
- [ ] Heart failure
- [ ] Heart murmur
- [ ] Hepatitis / jaundice
- [ ] Herpes / Fever blisters
- [ ] High blood pressure
- [ ] Hospitalized for any reason
- [ ] Joint replacement
- [ ] Kidney disease
- [ ] Liver disease
- [ ] Low blood pressure
- [ ] Lupus
- [ ] Mitral valve prolapse
- [ ] Nervous disorder
- [ ] Pacemaker
- [ ] Psychiatric treatment
- [ ] Radiation treatment
- [ ] Respiratory disease
- [ ] Rheumatic / Scarlet fever
- [ ] Shingles
- [ ] Sickle cell disease / Traits
- [ ] Sinus problems
- [ ] Sinus Trouble
- [ ] Stroke
- [ ] Thyroid problems
- [ ] Tonsillitis
- [ ] Tuberculosis (TB)
- [ ] Tumors or growths
- [ ] Ulcers
- [ ] Venereal disease
- [ ] X-Ray or cobalt treatment

Please list any serious medical condition(s) that you have ever had :

____

List any medications/substances which have caused an allergic reaction-

- [ ] Anesthetic (Novocain, ETC)
- [ ] Aspirin
- [ ] Barbiturates
- [ ] Codeine
- [ ] Dental anesthetics
- [ ] Erythromycin
- [ ] Iodine
- [ ] Jewelry / Metals
- [ ] Latex
- [ ] Local anesthetics
- [ ] Penicillin
- [ ] Plastic
- [ ] Sedatives
- [ ] Sleeping pills
- [ ] Sulfa Drugs
- [ ] Tetracycline
- [ ] Other

Please list any other drugs / Materials that you are allergic to :

____

Do you have any Past Surgical History?

☐ Mastectomy--------------------- ☐ Right ☐ Left ☐ Bilateral ☐ Lumpectomy-------------------- ☐ Right ☐ Left ☐ Bilateral

☐ Breast Biopsy------------------- ☐ Right ☐ Left ☐ Bilateral ☐ Joint Replacement, Knee----- ☐ Right ☐ Left ☐ Bilateral

☐ Joint Replacement, Hip------- ☐ Right ☐ Left ☐ Bilateral ☐ Kidney Removed-------------- ☐ Right ☐ Left

☐ Testicles Removed------------ ☐ Right ☐ Left ☐ Bilateral

☐ Breast Reduction ☐ Breast Implants ☐ Coronary Artery Bypass ☐ Kidney Biopsy

☐ Appendix Removed ☐ Bladder Removed ☐ Kidney Stone Removed ☐ Kidney Transplant

☐ Gallbladder Removed ☐ Ovaries Removed : Cyst ☐ Prostate Biopsy ☐ TURP

☐ Skin Biopsy ☐ Basal cell Cancer Surgery ☐ PTCA ☐ Melanoma Surgery

☐ Spleen Removed ☐ Heart Transplant ☐ Hysterectomy : Fibroids ☐ None

☐ Other ☐ Colectomy : IBD ☐ Colectomy : Diverticulitis

☐ Colectomy : Colon Cancer Resection ☐ Joint Replacement within last 2 years

☐ Mechanical Valve Replacement ☐ Biological Valve Replacement

☐ Ovaries Removed : Endometriosis ☐ Ovaries Removed : Ovarian Cancer

☐ Prostate Removed : Prostate Cancer ☐ Squamous Cell Carcinoma Surgery

☐ Hysterectomy : Uterine Cancer

Please list if you have any other Past Surgical history:

____

Social History-

Do you smoke? ☐ Yes ☐ No *How Much:* ________________ *How Long:*________________

Do you drink alcohol? ☐ Yes ☐ No *How Much:* ________________ *How Long:*________________

Do you recreational drugs such as marijuana? ☐ Yes ☐ No *How Much:* ________________ *How Long:*________________

Family Medical History-

Is there a family history of breast cancer? ☐ Yes ☐ No *Who is affected:* ☐ Mother ☐ Father ☐ Sister ☐ Brother

Is there a family history of any kind of cancer? ☐ Yes ☐ No *Who is affected:* ☐ Mother ☐ Father ☐ Sister ☐ Brother

Is there a family history of diabetes? ☐ Yes ☐ No *Who is affected:* ☐ Mother ☐ Father ☐ Sister ☐ Brother

Is there a family history of problems with anesthesia? ☐ Yes ☐ No *Who is affected:* ☐ Mother ☐ Father ☐ Sister ☐ Brother

☐ The information and preceding answers are true and correct to the best of my knowledge. I agree that, regardless of insurance coverage, I am responsible for payment for services rendered. If I ever have any changes in my health or if my medication change I will, without fail, inform the doctor at my next appointment.

Patient or Legal Guardian's Signature: ________________________________ Date: ________/________/________