WEST MAPLE PLASTIC SURGERY
PATIENT INFORMATION

DATE:	**MARITAL STATUS:**
NAME:	**CIRCLE ONE: MALE FEMALE**
STREET ADDRESS:	**DATE OF BIRTH: AGE:**
CITY: STATE: ZIP:	**SSN:**
HOME PHONE: **( )**	**HOW WERE YOU REFERRED TO US?**
BUSINESS PHONE: **( )**	**PRIMARY CARE PHYSICIAN NAME AND PHONE:** **( )**
BUSINESS NAME:	**PRIMARY CARE PHYSICIAN ADDRESS:**
PHARMACY NAME AND PHONE: **( )**	**EMERGENCY CONTACT PERSON:** **( )**
CELL PHONE: **( )**	**E-MAIL ADDRESS:**

COMPLETE IF SOMEONE OTHER THAN YOU IS RESPONSIBLE FOR PAYMENT:

NAME:	**PHONE:** **( )**
STREET ADDRESS:	**DATE OF BIRTH:**
CITY:	**SSN:**
STATE: ZIP:	**BUSINESS NAME:**

INSURANCE INFORMATION
PLEASE PRESENT YOUR CARD AT DESK

NAME OF PRIMARY INSURANCE:	**NAME OF SECONDARY INSURANCE:**
RELATIONSHIP TO CARDHOLDER: **(CIRCLE ONE) SELF SPOUSE CHILD**	**RELATIONSHIP TO CARDHOLDER:** **(CIRCLE ONE) SELF SPOUSE CHILD**

SPECIFIC REASON FOR WHICH YOU ARE SEEKING A PLASTIC SURGEON: _____

_____

HEIGHT:	**WEIGHT:**
ALLERGIES:	
DO YOU HAVE ANY SERIOUS ILLNESSES? (PLEASE LIST):	
PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:	
TOBACCO, MARIJUANA OR VAPING (PER DAY):	**COFFEE/TEA (PER DAY):**
ALCOHOL (PER DAY):	
DATE OF MOST RECENT PHYSICAL CHECK-UP:	**DID IT INCLUDE AN ELECTROCARDIOGRAM OR CHEST X-RAY:**
DATE AND LOCATION OF LAST MAMMOGRAM:	
IF YOU WERE REFERRED BY YOUR PHYSICIAN, PLEASE GIVE THEIR NAME, PHONE # AND REASON FOR REFERRAL:	
LIST PREVIOUS SURGERIES: **PROCEDURE: YEAR: HOSPITAL: ANESTHESIA: DOCTOR:**	

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO MY INSURANCE COMPANY BY THIS OFFICE FOR THE PURPOSE OF OBTAINING OR COLLECTING PAYMENT FOR SEVICES RENDERED.

SIGNATURE: **DATE:**

RELATIONSHIP:	AGE:	HEALTH: GOOD/POOR	FAMILY HISTORY:	RELATIONSHIP TO PATIENT:	RELATIONSHIP TO PATIENT:
MOTHER			CANCER		
FATHER			BLOOD CLOT/EMBOLISM		
BROTHERS			DIABETES		
			EPILEPSY		
			HEART DISEASE		
SISTERS			HIGH BLOOD PRESSURE		
			LUNG DISEASE		
			KIDNEY DISEASE		
CHILDREN			ASTHMA		
			TUBERCULOSIS		
			MENTAL DISEASE		
			RHEUMATOID DISEASE		

PLEASE ANSWER THE FOLLOWING QUESTIONS	YES	NO
ARE YOU OR COULD YOU BE PREGNANT?		
HAVE YOU EVER HAD A BAD REACTION TO ANESTHESIA?		
HAVE ANY OF YOUR FAMILY MEMBERS HAD A BAD REACTION?		
DO YOU REQUIRE LARGE AMOUNTS OF ANESTHESIA?		
HAVE YOU EVER HAD A BLOOD CLOT, DVT OR PE?		
HAVE ANY OF YOUR RELATIVES HAD A BLOOD CLOT, DVT OR PE?		
HAVE YOU BEEN TOLD THAT YOU HAVE A BLEEDING DISORDER?		
DO YOU HAVE HIGH BLOOD PRESSURE?		
DO YOU BLEED UNUSUALLY EASY?		
DO YOU BRUISE UNUSUALLY EASY?		
ARE YOU ALLERGIC TO ADHESIVE TAPE?		
ARE YOU A SLOW OR POOR HEALER?		
DO YOU HAVE A HEART MURMUR OR PROLAPSE?		
DO YOU FORM LARGE SCARS OR KELOIDS?		
DO YOU HAVE SHORTNESS OF BREATH WHEN WALKING?		
HAVE YOU TAKEN STEROID MEDICATIONS? (CORTISONE)		
HAVE YOU EVER HAD PSYCHIATRIC CARE?		
HAVE YOU EVER BEEN ADVISED TO SEE A PSYCHIATRIST?		