

FANTASTIC PLASTIC SURGERY & SKIN FITNESS

PATIENT REGISTRATION SHEET

SS#: _____

Today's Date: _____

LAST NAME: _____ FIRST : _____ MIDDLE INITIAL : _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PH: _____

Date of Birth: _____

E-MAIL ADDRESS _____

EMPLOYER: _____ EMPLOYER ADDRESS: _____

WORK PH: _____

MARITAL STATUS: M S D W SEP

SPOUSE'S NAME: _____ PHONE: _____

EMPLOYER: _____ EMPLOYER ADDRESS: _____

WORK PH: _____

Please list the nearest relative or friend, not living with you, that we may contact if we are unable to reach you, or in case of emergency:

NAME: _____ PHONE: _____

WHOM MAY WE THANK FOR REFERRING YOU TO FANTASTIC PLASTIC SURGERY & SKIN FITNESS?

REFERRED BY DOCTOR: (name) _____

REFERRED BY HOSPITAL: (name) _____

REFERRED BY FRIEND/PATIENT (*circle one or both*): (name) _____

OTHER (please specify): _____

MEDICAL HISTORY p. 1

Name: _____

Date: _____

CONFIDENTIAL RECORD: Information contained below will be used and disclosed as stated in our "Notice of Privacy Practices". This information will be used by Dr. Mischnick in making decisions concerning your care.

Sex (Circle): M F Your Personal Physician: _____

Date of Birth: _____ Current Weight: _____ Current Height: _____

Age: _____

Do you have, or have you had, any Health Problems? (Fill in blanks or Circle Yes or No where applicable)

ALLERGIES: To Food? _____
To Medication? _____

CURRENT MEDICATION: _____

Chronic Illnesses: _____

OPERATIONS: _____

DO YOU HAVE IMPLANTS? (Pacemaker, Breast Implants etc.): _____

Do you smoke? No Yes

Skin Cancer? No Yes

Other Cancer? No Yes

Family History of Cancer? No Yes

Are you pregnant? No Yes

Have you had pregnancies? No Yes Number? _____ Due Date: _____

Hormonal Problems? No Yes

Thyroid Problems? No Yes

Kidney Problems? No Yes

Gastrointestinal Problems? No Yes

Diabetes? No Yes

Psychological History—acute or chronic Depression? No Yes

Other diagnosis or problem? No Yes

Thrombophlebitis or Blood Clots? No Yes

Stroke? No Yes

Excessive Bleeding? No Yes

Mitral Valve Prolapse? No Yes

Lung or Breathing Difficulties? No Yes

(Asthma or Other)

High Blood Pressure? No Yes

Heart Attack? No Yes

Hepatitis (A or B or C) No Yes

AIDS No Yes

Do you have seizures? No Yes

Migraine Headache? No Yes

Multiple Sclerosis or other Neurological Problems? No Yes

Arthritis No Yes

Do you take Anti-inflammatories? No Yes Drug: _____

Do you take Blood Thinners (such as Coumadin or Plavix)? No Yes Drug: _____

FANTASTIC PLASTIC SURGERY
CONSENTS/AUTHORIZATIONS

Name: _____ Date of birth: _____

CONSENT TO TREATMENT

I hereby consent to medical treatment rendered by Fantastic Plastic Surgery.

Date

Signature (Patient or Parent if Minor)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the release of any medical information necessary to process this claim.

Date

Signature (Patient or Parent if Minor)

AUTHORIZATION TO PAY BENEFITS TO

I hereby authorize payment of medical/surgical benefits to be made to Fantastic Plastic Surgery.

Date

Signature (Patient or Parent if Minor)

CONSENT FOR PHOTOGRAPHY

Pre-treatment and post-treatment photographs are recommended to follow your medical care. Pre-treatment and post-treatment photos may be viewed for educational purposes by our physician or patients. Educational purposes may include: use in physician consults with individual patients or use in physician seminars presented to potential patients or for medical associations or for our web site; or on request, sent to your insurance company. This consent will be in effect until physician discontinues use of these photographs. It is our intention to handle all photographs with the highest regard for confidentiality and respect for the patient.

Date

Signature (Patient or Parent if Minor)

PRIVACY NOTICE

I acknowledge that I have received a copy of Fantastic Plastic Surgery & Skin Fitness's Notice of Privacy Practices.

Date

Signature (Patient or Parent if Minor)