American Institute for Plastic Surgery
Surgery Center of Texas

PATIENT INFORMATION

Today's Date: _____

Patient's Legal Name _____ **Nickname** _____
Last First Middle

Date of Birth: ___/____/_____ **Age**_____ **SSN:**_____-_____-_____ **Height:**__' ___" **Weight:**____ **lbs**

Sex: ☐Male ☐Female **Marital Status:** S/ M/ D/ W **Preferred Language** _____

Address: _____
Street & Apt # City State Zip

Phone **Privacy**
Home: (____) _____ - _____ ☐
Work: (____) _____ - _____ ☐
Cell: (____) _____ - _____ ☐

Emergency Contact, can we discuss your care?
Name: _____ Y☐ N☐
Relationship: _____
Home: (____) _____ - _____
Work: (____) _____ - _____

E-mail _____ **Preferred Method of Contact** _____

May we send you email correspondence? (Promotions, specials, appointments) Y☐ N☐

Occupation / Employer or school: _____/_____
☐ Full Time Employment ☐ Part Time Employment ☐ Retired
☐ Full Time Student ☐ Part Time Student ☐ Other

Tell us what procedures you are interested in? _____

Whom may we thank for referring you? ☐ Patient ☐ Physician ☐ Internet ☐Magazine ☐Radio ☐ Other

Name: _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT- If other than patient:

Legal Name _____ **Relationship** _____
Last First Middle

Date of Birth:___/____/_____ **Age:**_____ **SSN:**____-____-____ **License #/State:**_____/_____

Sex: ☐ **Male** ☐ **Female** **Phone: H:**_____ **W:**_____**Cell/Pager:**_____

Address: _____ Street
& Apt # City State Zip

PRIMARY INSURANCE COMPANY:

Insurance Company:_____ Phone #:_____

Claim Address: _____Insured Name and date of birth_____

Insurance Plan Type: PPO HMO POS EPO Group #:_____ ID#:_____

Workers Comp Manager / Phone:_____

PRIMARY CARE PHYSICIAN_____PH#: _____
☐I have a referral from my PCP ☐ I need a referral from my PCP

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HEALTH HISTORY

(All information is strictly confidential)

Name_____ Age_____ Today's Date_____

Reason For Visit_____

For Injuries: Date of Injury _____On the job? ☐ Yes ☐ No Occupation_____

Height:__' ___" Weight:_____ lbs. What is the most you have ever weighed: _____lbs

PAST MEDICAL HISTORY

Please check if you have, or ever had any of the following conditions: ☐None

Cardiovascular
- ☐Anemia
- ☐Angina / chest pain
- ☐ Arrhythmia
- ☐ Congestive heart failure
- ☐ Heart attack
- ☐Heart murmur
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart valve disorder
- ☐ Pacemaker / Stent
- ☐Rheumatic heart disease

Respiratory
- ☐ Asthma / Bronchitis
- ☐COPD / Emphysema
- ☐Pneumonia
- ☐Tuberculosis

Gastro-intestinal
- ☐ Liver disease
- ☐GERD
- ☐Hernia
- ☐ Hepatitis
- ☐Peptic ulcers

Blood
- ☐ Bleeding disorders
- ☐Blood transfusion
- ☐DVT / Blood clots / Pulmonary Embolism

Neurologic
- ☐Epilepsy
- ☐ Migraines
- ☐Paralysis
- ☐Stroke/ TIA

Mental Health
- ☐Alcohol/ Drug dependency
- ☐Anorexia /Bulimia
- ☐Depression
- ☐ Psychiatric care
- ☐ Suicide attempt

Skin/ Skeletal
- ☐Jaundice
- ☐ Skin disorder
- ☐Arthritis
- ☐Gout
- ☐Fracture

Immune/Infection
- ☐AIDS / HIV
- ☐Herpes / fever blister
- ☐Immune problem
- ☐MRSA/ VRE
- ☐ Venereal disease

Endocrine
- ☐Diabetes
- ☐ Thyroid disorders

Other
- ☐Glaucoma
- ☐Kidney disorders
- ☐ Impairment: Type_____
- ☐ Cancer: Type_____

Are you being treated for any other illness at this time? ☐Yes ☐ No. If yes, please explain:

_____

_____

Date of Last Physical _____ Results _____

Have you ever had SURGERY? ☐Yes ☐No If yes, please list:

Have you, or a family member ever had a problem with anesthesia? ☐Yes ☐No. If yes, please explain:

_____

Have you been diagnosed with a sleep disorder/sleep apnea? ☐Yes ☐No

Do you use a C-Pap Machine for your sleep disorder? ☐Yes ☐No

Do you have any DRUG ALLERGIES? ☐Yes ☐No. If yes, please note name of drug and reaction:

FAMILY HISTORY (Only list blood related relatives.) ☐None

☐Diabetes		☐ Blood Clots		☐High Blood Pressure	
☐Stroke		☐Heart Disease		☐Cancer/ type	
☐ Other					

LIST ALL MEDICATIONS YOU ARE TAKING WITH NAME AND DOSAGE: ☐ No Meds

		☐Weight control	☐Estrogen/ hormones
		☐Accutane (past year)	☐Chemotherapy
		☐Antibiotics	☐Antidepressants
		☐Aspirin/ NSAID's	☐Steroids
		☐Blood thinners	☐Vitamins/ supplements
		☐Birth control	☐Herbal/ homeopathics

Are you taking or have you ever taken recreational drugs? ☐ Yes ☐ No What type_____
Please give more details _____

Do you smoke?	☐Yes	☐No	Quit? _____	How much?_____	# per day
Do you drink?	☐Yes	☐No	☐Socially	☐ Occasionally	☐ Moderately

♀ WOMEN'S HEALTH ☐N/A

Pregnancies: _____ Live births: _____ Miscarriages: _____ Abortions: _____

Date of Last Menstrual Period: _____ Are you pregnant? ☐Yes ☐No

Date of Last Mammogram:_____ Results: _____

Current Bra Size: _____ Breast Cancer ☐Yes ☐No History of Breast Biopsy ☐Yes ☐No

REVIEW OF SYSTEMS Please circle the following symptoms you have had recently: ☐No Symptoms

General:	Fatigue. Fever. Chills. Sweats. Sleep disturbance. Recent weight gain or loss.
Eyes, Ears, Nose, & Throat:	Blindness. Blurred vision. Cataracts. Contact lenses. Double vision. Dry eyes. Eye irritation. Eye pain. Excessive tearing. Red eyes. Sensitivity to light. Visual changes. Ear discharge. Difficulty breathing through nose. Dizziness. Hearing loss. Ringing in the ears. Chronic nasal congestion. Nose bleeds. Loss of sense of smell. Past nasal injury. Sinus problems. Ulcer/sore. Capped teeth. Loose teeth. Tooth pain. Dental problems. Dentures. Difficulty swallowing. Hoarseness. Snoring.
Cardiovascular:	Chest pain. Congestive heart failure. Irregular / rapid heartbeat. Heart attack. Low blood pressure. Mitral valve prolapse/ need for antibiotics for dental procedures. Foot swelling. Palpitations/ Skipped beats. Poor circulation. Rheumatic fever. Varicose veins.
Respiratory:	Bronchitis. Bloody cough. Shortness of breath. Pneumonia. Recent cough. Wheezing. Tuberculosis.
Gastrointestinal:	Bloating. Blood in vomit / stools. Changes in appetite. Change in bowel habits. Chron's colitis. Constipation. Diarrhea. Hemorrhoids/ rectal bleeds. Gastritis/ reflux. Hepatitis/ jaundice. Irritable bowel syndrome. Nausea/ vomiting. Peptic ulcers. Ulcerative colitis.
Genitourinary:	Urinary infections. Urinating: Blood/ Difficulty/ Frequent/ Pain/ incontinent. STD. Yeast infections.
Musculoskeletal:	Arthritis. Difficulty walking. Extremity pain. Injuries. Joint pain. Leg cramps. Lupus Erythematosus, Rheumatoid arthritis. Unusual muscle weakness. Swelling.
Neurologic:	Dizziness/ fainting. Numbness. Migraines/ headaches. Seizures/ epilepsy. Sensory loss. Stroke. Weakness/ loss of balance.
Psychiatric:	Alcoholism. Anxiety. Depression. Drug abuse. Financial trouble. Marital problems. Schizophrenia.
Heme/ Immunologic:	Bleeding gums. Blood clot/ clotting disorder. Blood transfusion. Easy bruising. HIV complications. MRSA / VRE infections. Sickle Cell Anemia. Swollen lymph nodes.
Endocrine/ Hormonal:	Adrenal disorders. Labile blood glucose levels. Neuropathy. Steroid use. Thyroid symptoms.
Skin Disease:	Acne. Burn injury. Difficulty healing wounds. Excessive or unsatisfactory scarring. Itching/ Hives. Moles changing in appearance. Skin Cancer. Unexplained rash/ inflammation.
Breasts:	Abnormal Mammogram. Bloody discharge. Benign lump/ tumor. Cancer. Clear discharge. Milky discharge. Fibrocystic breasts. Pain. Reduction. Saline breast implants. Silicone breast implants.

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

X_____
Signature of Patient, Parent, Guardian or Personal Representative Date Time

_____
Name of Patient, Parent, Guardian or Personal Representative Date Time

_____
Reviewed by (Clinic Personnel, if applicable) Date Time

_____
Reviewed by (PreOp Personnel) Date Time

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****ALL PATIENTS – please complete sections at the bottom of the page**

INSURANCE PATIENTS – please complete the following:

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and instruct my insurance carrier to make payment directly to American Institute for Plastic Surgery (AIPS) and/or Surgery Center of Texas for charges incurred. I further assign all rights to payment due for medical and/or surgical services under listed policies to AIPS Surgery Center of Texas, Anesthesia, Pathology and Radiology providers. I understand that any payment made on my behalf is not refundable to me. **PLEASE INITIAL:** _____

FINANCIAL RESPONSIBILITY: I understand that AIPS/Surgery Center of Texas/Anesthesia/Pathology and Radiology providers as a courtesy will file with my insurance carrier. I understand that all co-pays and deductibles are due when services are rendered. I further understand that although these providers will file with my insurance, I am ultimately responsible for all charges incurred. **PLEASE INITIAL:** _____

WORKER'S COMP PATIENTS – please complete the following:

Date of Accident: _____/_____/_____ Supervisor's Name / Phone #:_____/_____

Employer's Name: _____

Employer's Address: _____

I give permission for my information regarding my medical condition to be released to my employer, insurance carrier, case manager and any medical personnel as needed. This will include all tests, reports, appointment information, billing information, forms and correspondence. PLEASE INITIAL: _____

ALL PATIENTS - Please complete the following sections:

INFORMED CONSENT-PATIENT COMPUTER IMAGING: In the course of consultation, I may have been shown brochures or photographs of actual patients on a computer screen. I understand that those pictures and any alterations of these pictures are solely for the purpose of illustration. Furthermore, I understand that the outcome of any type of surgical procedure is related to my individual characteristics and health. I understand that because of the differences in how living tissues react to surgery, there may be no relationship between the electronic images created and my actual final surgical result. Use of computer imaging system offers an opportunity for me to discuss my desires and allows for improved communication with the medical staff. **PLEASE INITIAL:** _____

RELEASE OF PHOTOGRAPHIC IMAGES: I hereby grant permission for the use of any illustrations, photographs, or imaging records, created in my case, for use in scientific and professional journals, the AIPS website, or other medical or patient education material and presentations at any time during or after treatment, with complete confidentiality of my identity. **PLEASE INITIAL:** _____

CONSENT/RESTRICTION OF THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS: I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans of future care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the healthcare professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, a means by which a third party payer can verify that services billed were actually provided, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals. I wish to have the following restrictions to use or disclosure of my health information. ☐ **None** ☐ **Other**_____

SIGNATURE OF PATIENT or GUARDIAN:

_____

Patient, if minor (Parent or guardian signature) **Date** **Time**