ASSOCIATED PLASTIC SURGEONS, P.C.

E. Philip Gutek, M.D.
Mark W. McClung, M.D.
Sheryl L. Young, M.D.
Joseph V. Cannova, Jr., M.D.
Jon E. Rast, M.D.

Date _____

Account Number _____

APS Physician _____

PATIENT HEALTH INFORMATION

PLEASE COMPLETE ALL ITEMS. PLEASE PRINT.

Patient Name Last	First	MI				Marital Status S M W D Sep
Street Address					( ) Home Telephone Number	( ) Cell Telephone Number
City	State	Zip			E-mail	
Birthdate	Age	Race	Sex	Social Security #	Occupation (indicate if student)	( ) Work Telephone Number
Employer				Address		
Insured's Name			Relationship to Patient	Social Security #	Birthdate	( ) Home Telephone Number
Insured's Employer					Employer's Telephone Number (extension)	
Employer's Street Address		City			State	Zip
In case of emergency (or other parent) Name			Relationship to Patient		( ) Home Telephone Number	( ) Work Telephone Number
Street Address		City			State	Zip

Referred by: Family Doctor, Former Patient, Yellow Pages, Internet, Advertisement — Name, Address

Were you injured in an accident? **Yes** **No** **Were you injured in an automobile accident** Yes No

Were you injured on the job? **Yes** **No** **Date of injury** _____

FOR OFFICE USE ONLY: **Spoke to:** **Date:**

Workman's Compensation Billing: **Contact person:**

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD

I agree to be photographed by Associated Plastic Surgeons for the purpose of medical necessity, insurance authorization, medical, scientific and educational purposes.

Date _____ Signature _____

The patient is responsible for all fees regardless of insurance coverage. If surgery is indicated, the patient is responsible for furnishing insurance information to the office prior to surgery. You have my permission to contact me at home or work.

Date _____ Signature _____

MEDICARE LIFETIME CONSENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Drs. Gutek, McClung, Young, Cannova and Rast for any services furnished to me by these physicians. I authorize any holder of medical information about me to release it to the Centers for Medicare Services and its agents any information needed to determine these benefits payable for related services.

Date _____ Signature _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Drs. Gutek, McClung, Young, Cannova and Rast to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date _____ Signature _____

REASON FOR VISIT (please describe) _____

Have you consulted any other doctor(s), including plastic surgeons, about this? No _____ Yes _____

If yes, please list name(s) _____

ALLERGIES: PLEASE INDICATE ANY REACTIONS TO MEDICATIONS, DRUGS, SUTURE AND/OR TAPE AND THE TYPE OF REACTION (i.e., hives, shock, breathing disorders)_____

_____

Are you allergic to latex? No_____ Yes_____

If allergy is to tape, what type of tape may be used _____

CURRENT HEALTH STATUS: Height _____ Weight _____ Weight Loss/Gain in past year_____ lbs

Date of most recent physical examination _____ Did it include: EKG_____ Chest x-ray _____ Lab Work _____

Name and address of doctor performing physical _____

What is your approximate daily consumption of: coffee/tea/cola _____ tobacco _____ alcohol _____

Other intoxicating or mind-altering drugs: _____

Have you ever been tested for HIV (AIDS)? No_____ Yes_____ Date of Test _____ Results: Positive Negative

Have you ever had hepatitis? No_____ Yes_____ If yes, please specify type and date_____

Have you ever had scarlet fever? No_____ Yes_____ If yes, date _____ Rheumatic fever? No_____ Yes_____ If yes, date _____

Are you presently pregnant?	No	Yes	Have you reacted badly to being put to sleep for surgery?	No	Yes
Has any member of your family ever reacted badly to being put to sleep for surgery?	No	Yes	Do you require large amounts of local anesthetic for medical or dental procedures?	No	Yes
Do you have high blood pressure?	No	Yes	Do you bleed unusually easily (from cuts, surgery, tooth extraction)?	No	Yes
Do you bruise unusually easy?	No	Yes	Are you a poor or slow healer?	No	Yes
Do you form large scars or keloids?	No	Yes	Do you have any skin disease, hives, eczema or rash?	No	Yes
Do you have frequent infections or boils?	No	Yes	Have you taken steroid medications, Cortisone, or ACTH?	No	Yes
Do you have shortness of breath with walking?	No	Yes	Does your religion prohibit blood transfusions?	No	Yes
Do you have, or have you had any significant emotional problems?	No	Yes	Have you ever had psychiatric care?	No	Yes
Have you ever been advised to see a psychiatrist/psychologist?	No	Yes	Are you taking medication for weight loss?	No	Yes
			Are you taking herbal medicine?	No	Yes

CURRENT MEDICATIONS: Please list ALL medications you are now taking and their dosages (including birth control pills, diuretics [water pills], vitamins, blood pressure or heart medications, tranquilizers, hormones, blood thinners, aspirin, Bufferin, etc.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Past Medical History

Have you had any illnesses, injuries or disorders of the following? (circle all that apply)

Brain (INCLUDING STROKES, EPILEPSY)	Face (PARALYSIS)	Lungs (INCLUDING ASTHMA)	Intestines	Blood	Bones or Joints
Eyes (INCLUDING GLAUCOMA, DRYNESS)	Nose, Sinus, Throat	Heart or Blood Vessels	Liver	Reproductive System	Arms or Legs
Ears	Breasts	Stomach	Urinary System	Nervous System	Endocrine or Diabetes

If circled, please explain: _____

Surgeries/Injuries

TYPE	YEAR	TREATMENT FACILITY	DOCTOR	AFTER-EFFECT

Family History

	Age	Health Status
Mother		
Father		
Brother(s)		
Sister(s)		
Children		

Has any relative had:		
Tuberculosis	No	Yes
Cancer	No	Yes
Diabetes	No	Yes
Heart Disease	No	Yes
Epilepsy	No	Yes
High Blood Pressure	No	Yes
Lung Disease	No	Yes
Kidney Disease	No	Yes
Blood/Bleeding Disorder	No	Yes
Asthma	No	Yes
Mental Disease	No	Yes

I certify this information is complete and accurate. I authorize treatment of the person named on this form.

SIGNATURE

NAME (IF FORM COMPLETED BY OTHER THAN PATIENT)

RELATIONSHIP