



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)				Relationship to Patient		() Home Telephone Number		() Work Telephone Number			
Name											
Street Address				City		State		Zip			
Referred by:		Family Doctor		Name							
		Former Patient		Address							
		Yellow Pages									
		Internet									
		Advertisement									
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
<small>(INCLUDING STROKES, EPILEPSY)</small> | Face
<small>(PARALYSIS)</small> | Lungs
<small>(INCLUDING ASTHMA)</small> | Intestines | Blood | Bones or Joints |
| Eyes
<small>(INCLUDING GLAUCOMA, DRYNESS)</small> | 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	Has any relative had:	
Mother		Tuberculosis	No Yes
Father		Cancer	No Yes
Brother(s)		Diabetes	No Yes
Sister(s)		Heart Disease	No Yes
Children		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 <small>(IF FORM COMPLETED BY OTHER THAN PATIENT)</small>	_____ RELATIONSHIP
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