PATIENT INFORMATION

(Please print clearly)

PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	TODAY'S DATE	DATE OF BIRTH	AGE	SEX ☐ M ☐ F

ADDRESS (STREET)	APT. #	SOCIAL SECURITY NUMBER

CITY	STATE	ZIP	HOME PHONE

MARITAL STATUS ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ SINGLE	CELL PHONE

EMPLOYER (NAME OF COMPANY)	PHONE - WORK

IF MARRIED

SPOUSES NAME (LAST)	(FIRST)	(MIDDLE)	SOCIAL SECURITY NUMBER

EMPLOYER (NAME OF COMPANY)	EMPLOYER PHONE

IF MINOR

NAME OF RESPONSIBLE PARTY (LAST)	(FIRST)	(MIDDLE)	SOCIAL SECURITY NUMBER

ADDRESS (STREET)	APT. #	PHONE

CITY	STATE	ZIP	RELATIONSHIP

EMPLOYER (NAME OF COMPANY)	EMPLOYER PHONE

MEDICAL INSURANCE

NAME OF INSURANCE COMPANY	SUBSCRIBER	RELATIONSHIP TO PATIENT

IF YOU HAVE SECONDARY INSURANCE

NAME OF INSURANCE COMPANY	SUBSCRIBER	RELATIONSHIP TO PATIENT

IF THIS WAS A PERSONAL INJURY, DATE OF ACCIDENT?	

IF YOUR CASE IS BEING HANDLED BY AN ATTORNEY: NAME OF ATTORNEY	ATTORNEY PHONE

ATTORNEY ADDRESS (STREET)	CITY	STATE	ZIP

WERE YOU REFERRED TO OUR OFFICE? ☐ YES ☐ NO	IF YES, BY PHYSICIAN? (NAME)	OTHER (NAME)

PERSON WHO ***DOES NOT LIVE WITH*** YOU WE CAN CONTACT IF WE CANNOT REACH YOU: NAME	PHONE	RELATIONSHIP ☐ RELATIVE ☐ FRIEND ☐ NEIGHBOR

I authorize the physician to release any information required in the course of my treatment and permit payment directly to him of any benefits due for services rendered. ***I recognize and accept responsibility for any balance remaining after payment or no payment of such benefits.***

I also understand if my insurance carrier requires a referral, second opinion or pre-authorization, I am responsible. Failure may result in my insurance carrier denying my claim and I will be responsible for any balance resulting if this occurs.

I consent to be photographed. ~~These photographs will become part of my medical record.~~ ☐ Yes ☐ No

Patient **X** _____ Date_____ Responsible Party **X** _____ Date_____

MEDICAL HISTORY

PATIENT NAME	DATE	BIRTHDATE

PRIMARY PHYSICIAN / PEDIATRICIAN

HEIGHT	WEIGHT	AGE

WHO REQUESTED THIS CONSULT TODAY?

CURRENT MEDICAL PROBLEMS

MEDICATION TAKEN DAILY (PLEASE LIST)

DRUG SENSITIVITIES AND/OR ALLERGIES (PLEASE LIST)

PREVIOUS OPERATIONS WITH DATES

FAMILY HISTORY:

Diabetes ☐ Yes ☐ No Heart Disease ☐ Yes ☐ No Cancer ☐ Yes ☐ No Other _____

Do you smoke? ☐ Yes ☐ No How much per day _____

Do you drink? ☐ Yes ☐ No How often? _____

Do you take aspirin, ibuprofen, or similar medication? ☐ Yes ☐ No

SYMPTOMS

Check (✓) conditions you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

SYMPTOMS (Continued)

Check (✓) conditions you currently have or have had in the past year.

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN Only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN Only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

CONDITIONS

Check (✓) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Any medical problems not listed above you would like the doctor to be informed about? _____

_____

Have you ever had a blood transfusion? ☐ Yes ☐ No Would you accept one? ☐ Yes ☐ No

The medical history above is true and accurate to the best of my knowledge.

X _____ Date _____

Plastic Surgery Associates and Bluemound Cosmetic Surgery Center

CANCELLATION POLICY

Payment of cosmetic/elective self-pay surgery is expected 14 days prior to your surgery. This fee will be paid at the time of your history and physical (to be scheduled with an R.N.). This payment can be paid in the form of a personal check, cash, cashiers check or credit card. Within 14 days of your surgery no personal checks will be accepted. Full refunds will be given if cancellation occurs before 3 business days prior to surgery. If a cancellation is within 3 business days before surgery, a $500.00 fee will be forfeited to the Bluemound Surgical Center and deducted from your payment.

By signing this I agree with the above policy.

_____ _____

Signature Date

_____ _____

Signature of Witness Date

REVISIONAL SURGERY

Cosmetic/elective self-pay surgeries are performed regularly at our office. A cosmetic surgeon can expect a 10 percent revisional rate. It is the policy of our office that secondary fees for revisions include the cost of anesthesia services and a reduced cost for use of the surgical suite. The surgeon's fee is negotiable.

By signing this I agree with the above policy.

_____ _____

Signature Date

_____ _____

Signature of Witness Date

Plastic Surgery Associates
N4 W22370 Bluemound Road
Waukesha, WI 53186

NOTICE OF PRIVACY PRACTICES

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security #: _____

What is the best telephone number to reach you at? _____

Can we leave a message for you at this number? _____Yes _____No

Please list the names of individuals with whom we can discuss your medical care.

_____ _____
Name Relationship Name Relationship

_____ _____
Name Relationship Name Relationship

☐ **Please check this box if you do not want us to discuss your medical care with anyone except for yourself.**

By signing this form you acknowledge that Plastic Surgery Associates/Bluemound Surgery Center has given you a copy of its Notice of Privacy Practices.

_____ _____
Patient or Personal Representative Signature Date

_____
If Personal Representative, Describe Relationship

SMOKING POLICY

Welcome to Plastic Surgery Associates. We are a team of plastic surgeons dedicated to delivering the highest quality of care in the community. With that said, we find it important to notify our patients of potential risks related to personal habits that ultimately may affect wound healing and success of surgery performed. It has been well documented in our literature that smoking and/or second hand smoke can inhibit wound healing and lead to worsening complications related to any type of surgical procedure performed. It is our recommendation at Plastic Surgery Associates that our patients stop smoking and avoid exposure to second hand smoking two weeks prior and two weeks after any surgical procedure. If you have any questions pertaining to this policy, please do not hesitate to ask the nurse or the physician at the time of your consultation.

We want to thank you for choosing Plastic Surgery Associates.

By signing this I understand the above policy.

_____ _____ _____
Signature Date Time

_____ _____
Signature of Witness Date