WELCOME TO OUR OFFICE!

1879 Nightingale Lane, Suite A-2
Tavares, Florida 32778
Ph: 352-742-0336
Fx: 352-742-0059

Date_____

Paitent Name_____

Date of Birth _____ Social Security _____

Mailing Address _____

City_____ State _____ Zip _____

Home Phone _____ Cell _____

Employer _____ Phone _____

May we send e-mail to you? YES NO E-mail address _____

Spouse Name _____

Employer _____ Phone _____ Cell _____

Primary Ins _____ **Secondary Ins** _____

Subscriber/Responsible Party (if other than pt)

Name _____ Relation _____

Date of Birth _____ Social Security_____

Phone _____ Work _____ Cell _____

Emergency Contact

Name_____ Relation _____

Home Phone _____ Work_____ Cell _____

Any restrictions on calling your home, work or cell? YES NO

If yes, explain _____

Any restrictions on correspondence? YES NO

If yes, explain _____

How did you learn about our practice? _____

If referred by an individual, may we send a thank you letter? YES NO

PLEASE GIVE YOUR INSURANCE CARD(S) & A PHOTO ID TO OUR FRONT DESK TO COPY

If you are a member of an HMO or PPO you may need authorization from your primary care physician to see our doctors. We may not be able to see you if authorization cannot be secured. We will be happy to reschedule your appointment once authorization has been obtained or you may choose to accept financial responsibility for your visit.

I authorize the release of any medical or other information necessary to process insurance claims. I authorize my insurance benefits to be paid directly to Plastic Surgery Center of Lake County. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

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_____

Signature (patient/responsible party) **Date**

HEALTH HISTORY

Correct answers to the following questions allow our doctors to treat you on a more individual basis, providing the care appropriate to your particular needs.

Name: _____ **Date of Birth:** _____ **Age:** _____

Today's Date:

- Why are you seeking a plastic surgery consult? _____

Please answer each question by checking yes or no. If in doubt, leave blank:

- Are you in good health now? ..... Yes / No
- Are you under the care of a physician? ..... Yes / No
  - If so, what is the condition being treated? _____
- Have you ever been hospitalized or had a serious illness? ..... Yes / No
  - If yes, please explain _____
- (Women) : Are you pregnant? If so, give due date: ..... Yes / No
- Do you use tobacco in any form? ..... Yes / No
  - If yes, how much / often? _____
  - If you quit, how long ago? _____
- Do you now or have you ever regularly consumed alcoholic beverages (more than 2 drinks / day for men, 1 / day for women)? ..... Yes / No

Do you have, or have you ever had, any of the following?

	YES	NO	YES IN PAST BUT NOT NOW
GENERAL			
Tire Easily			
Marked Weight Change			
Night Sweats			
Persistant Fever			
SKIN			
Eruptions, Rash, Hives			
Change in Skin Color			
EYES			
Visual Change			
Glaucoma			
EARS			
Loss of Hearing			
Ringing in Ears			
NOSE			
Frequent Nosebleeds			
Sinus Problems			
THROAT			
Soreness / Hoarseness			
NERVOUS SYSTEM			
Stroke			
HEADACHES			
Convulsion / Epilepsy			
Numbness / Tingling			
Dizziness / Fainting			
Psychiatric Treatment			
ENDOCRINE			
Thyroid Condition / Goiter			
Diabetes			
If so, do you take medicine			
Family history of diabetes			

	YES	NO	YES IN PAST BUT NOT NOW
HEART / BLOOD VESSELS			
Rheumatic Fever			
Heart Murmur			
Chest Pain / Discomfort			
Heart Attack / Trouble			
Shortness of Breath			
Swelling of Ankles			
High Blood Pressure			
Congenital Heart Disease			
Artificial Heart Valve			
Pacemaker			
Heart Surgery			
Other (List on Reverse)			
BONE / MUSCLES			
Arthritis / Rheumatism			
Artificial Joints			
DIGESTIVE SYSTEM			
Hepatitis			
Jaundice			
Ulcers			
Change in Appetite			
Black / Bloody or Pale Stools			
URINARY			
Kidney Disease			
Increase in Frequency (night)			
Burning on Urination			
Urethral Discharge			
Bloody Urine			
Venereal Disease			
BLOOD			
Bruise Easily			
Anemia			
Blood Transfusion			

OVER

HEALTH HISTORY

■ **Are you allergic to any medications? If so, please list them, as well as the reaction.**

_____
_____
_____

■ **List all *prescription* medications you are currently taking:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

■ **List all *over the counter* medications you are currently taking:**
(Including vitamins, herbals, aspirin, ibuprofen, acetaminophen, etc)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

■ **Is there any disease, condition, or problem not listed, that you think we should know about?**
Or, is there any activity your doctor says you cannot do? If so, please explain.

_____
_____

■ **Name of your primary care physician** _____ Phone _____

■ **Name of the referring physician** _____ Phone _____

■ **Please list any previous surgeries, and the date performed:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

■ **Is there anything else you would like the doctor to know?** _____

To the best of my knowledge, all the preceding answers are true and correct.
If I ever have any change in my health, or change my medication, I will inform the doctor at the next appointment.

Signature of patient, Parent/Guardian _____ Date _____

Signature of Doctor _____ Date _____