Patient Information

First Name: ______________________________

MI: __________

Last Name: ______________________________________

Social Security #: ______________________________________

Circle One:

Sex: M F Marital Status: _________________________

Date of Birth: __________________________

Age: ___________________

Race: __________________________________

Ethnicity: ________________________________

Preferred Language: ______________________________

Street Address: ____

City, State, Zip: ____

Employer: ____

Occupation: _____________________________________

Home Phone: ___________________________________

Work Phone: ____

Cell Phone: ______________________________________

Preferred Phone Number?

□ Home □ Work □ Cell

What is your preferred method of contact?

□ Email Address ___________________________________

□ Paper/US Mail

Have you ever been seen in this office before? ______________

If yes, who did you see and how long ago? ____________________

PHARMACY

Pharmacy: ______________________________

Phone: ______________________________

EMERGENCY CONTACT

Emergency Contact: ___________________________________

Emergency Contact Phone: ____________________________

REFERRING PROVIDER

Referring Provider: _____________________________

Address: ____

Phone: ________________________________

Patient's Name:____

PRIMARY INSURANCE

Name of Insurance:____

Name of Subscriber:____

Subscriber's Date of Birth:_______________________________________

Subscriber's SSN #:____

Your Relationship to the Subscriber:___________________________________

SECONDARY INSURANCE

Name of Insurance:____

Name of Subscriber:____

Subscriber's Date of Birth:_______________________________________

Subscriber's SSN #:____

Your Relationship to the Subscriber:_______________________________

Is your visit today the result of a work injury? ◻ YES ◻ NO

Is your visit today the result of an auto accident? ◻ YES ◻ NO

Completed By:____
Patient/Responsible Party Date

Patient's Name: ____ Date: ____________________

Patient Past Medical History – Check all that apply

□ No Pertinent Past Medical History

□ Anemia

□ Arthritis

□ Asthma

□ Bleeding Disorder

□ Blood Clots

□ Breast Cancer

□ Cancer

□ COPD

□ Depression

□ Diabetes

□ Glaucoma

□ Gout

□ Heart Attack

□ Heart Disease

□ Hepatitis

□ High Blood Pressure

□ High Cholesterol

□ HIV / AIDS

□ Hives

□ Kidney Disorder

□ Kidney Stones

□ Lung Disease

□ Other

□ Psychiatric Disorder

□ Reflux Disease

□ Seizures

□ Skin Cancer

□ Stroke

□ Thyroid Disorder

Patient Past Surgery/Hospitalizations: ____

____

Dominant Hand - Check one

□ Right Hand □ Left hand □ Ambidextrous

Review of Systems – Check all that apply

Symptom			Symptom		
Fever	Y □	N □	Numbness	Y □	N □
Chills	Y □	N □	Joint Pain	Y □	N □
Swollen Lymph Nodes	Y □	N □	Weakness	Y □	N □
Chest Pain	Y □	N □	Limited Motion	Y □	N □
Cough	Y □	N □	Weight Loss	Y □	N □
Difficulty Breathing	Y □	N □	Nausea	Y □	N □
Blurred Vision	Y □	N □	Vomiting	Y □	N □
Headache	Y □	N □	Breast Lump	Y □	N □

Patient Family History	Check All That Apply	Afflicted Family Member
No Contributing Family History		
Abnormal Bleeding		
Abnormal Clotting		
Adopted		
Anesthesia Problems		
Autoimmune Disorders		
Brain Tumor		
Breast Cancer		
Cleft Lip		
Cleft Palate		
Dementia		
Depression		
Diabetes		
Drug Allergies		
Endocrine Disease		
Hearing Loss		
Heart Disease		
Hemophilia		
High Blood Pressure		
Kidney Disease		
Liver Disease		
Lung Cancer		
Malignant Hyperthermia		
Other		
Other Cancer		
Ovarian Cancer		
Prostate Cancer		
Skin Cancer		
Skin Disease		
Substance Abuse		
Von Willebrand		

Patient's Name: ______________________________

Allergies: ______________________________

____

____

Current Medication and Dosage: ______________

____

____

____

____

Patient Social History:

ALCOHOL

- □ Denies Alcohol Use
- □ Admits Alcohol Use Socially
- □ Admits Alcohol Use Daily
- □ Admits to History of Alcoholism

ILLEGAL DRUGS

- □ Denies Using Illegal Drugs
- □ Admits to Using Illegal Drugs
- □ Admits to History of Drug Abuse

Smoking Status:

- □ Current
- □ Former Started:
- □ Never Ended:

Height / Weight / BMI

Height (INCHES): ____________________

Weight (LBS): ____________________

BMI: ____________________

Height Cheat Sheet:

4ft = 48 in. 4ft 6 in. = 54 in. 5ft = 60in.

5ft 6in. = 66in. 6ft = 72in. 6ft 6in. =78in

TODAY'S DATE: ___________________

Patient's Name: (please print) __________________________________

DOB: ______________________________

Medical History Verification

All information provided is accurate and complete to the best of my knowledge.

Patient Initials:____________ **Parent or Guardian Initials**:______________ **Date:** ______________

AUTHORIZATION OF RELEASE OF INFORMATION

I hereby authorize the physician to release information requested by my insurance company or Workman's compensation carrier. I also authorize my physician to release information to any hospital or physician I may be referred to or referred from.

Patient Initials:____________ **Parent or Guardian Initials**:______________ **Date:** ______________

ASSIGNMENT OF BENEFITS

I hereby authorize assignment and payment directly to my physician major benefits due to me.

Patient Initials:____________ **Parent or Guardian Initials**:______________ **Date:** ______________

PRIVACY NOTICE

I acknowledge that I have received a copy of Plastic & Reconstructive Surgery of Chester County's Privacy Notice.

Patient Initials:____________ **Parent or Guardian Initials**:______________ **Date:** ______________