PLASTIC SURGERY
OF TEXAS

PATIENT INFORMATION

Date: _____-_____-_____ Who referred you to us? _____

NAME_____ D.O.B: _____-_____-_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

H. PHONE # _____ CELL PHONE#_____

WORK PHONE# _____ SS#_____

EMAIL_____

MAY WE CONTACT BY: TEXT / EMAIL (CIRCLE ONE OR BOTH)

EMPLOYER:_____ ADDRESS:_____

IN CASE OF EMERGENCY CONTACT: _____

PHONE #_____ RELATIONSHIP:_____

REASON FOR OFFICE VISIT: _____

PATIENTS SIGNATURE:

X_____

DATE: _____-_____-_____

MEDICAL HISTORY

Date: ____-____-_____ Name:_____ Age:_____ D.O.B: ____-____-_____

Referring Doctor? _____
If no referring doctor, then how did you hear about us? _____

CONFIDENTIAL INFORMATION: Information contained herein will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by the doctor in his decisions regarding your care.

Why are you coming to see us? _____
How long has the problem been present? _____
Has the problem been treated by a doctor? No Yes, explain _____
_____

Do you have or have you ever had the following? CIRCLE Yes or No, if Yes, give date of occurrence

Stroke	No Yes _____	Cancer	No Yes _____	Other	No Yes _____
Diabetes	No Yes _____	Bleeding Tendency	No Yes _____	Explain:	
High Blood Pressure	No Yes _____	Stomach Ulcer	No Yes _____		
Heart Disease	No Yes _____	Back Problems	No Yes _____		
Heart Attack	No Yes _____	Hepatitis	No Yes _____	Height: _____	
Lung Disease	No Yes _____	Leukemia	No Yes _____		
Bronchitis	No Yes _____	Psychiatric	No Yes _____	Weight: _____	
Pneumonia	No Yes _____	Thyroid Disease	No Yes _____		
Tuberculosis	No Yes _____	Kidney Disease	No Yes _____		

Have you ever had a blood transfusion? No Yes _____ Have you ever taken steroids? No Yes _____

Please list all operations or surgeries that you have had: _____
Serious injuries or accidents: _____
When was your last physical exam by a physician? _____
Have you or anyone in your family ever had problems with anesthesia? No Yes, explain _____
List all medications that you take on a regular basis: _____
List all medications that you take on an occasional basis: _____
List all allergies that you have: _____
Do you smoke? No Yes, How much? _____ Do you regularly drink alcoholic beverages? No Yes, How much?_____
Do you wear glasses? No Yes Contact Lenses? No Yes Dentures? No Yes
Where do you live? _____ What is your occupation? _____
Are you married? _____ What are your hobbies? _____
Is your mother living? Yes No, if No, would you list her age and cause of death?_____
Her state of health: _____
Is your father living? Yes No, if No, would you list her age and cause of death?_____
His state of health: _____
Are your siblings healthy? Yes No, if No, please explain: _____
Have you been sick or had any illnesses in the last month? No Yes, explain _____

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PATIENT PHOTOGRAPH CONSENT FORM

The undersigned hereby authorizes _____ M.D. to take photographs of me and to use them as an aid in my treatment. I understand these photographs will become part of my permanent record.

Signature: _____ Date: _____

PST Rep: _____ Date: _____

In an effort to give the patient a better understanding of the results that can be achieved, we often use visual aids such as the photographs/slides that were taken of your particular case.

By signing the consent, you allow your photographs/slides to be shared by others who have the same or similar procedure. Please understand that your photographs/slides never show faces unless, of course, the face is involved.

Signature: _____ Date: _____

PST Rep: _____ Date: _____

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ACKNOWLEDGEMENT OF REVIEW
OF NOTICE OF PRIVACY PRACTICES

I have reviewed Plastic Surgery of Texas Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient

_____

Print Name

_____

Date

_____

Signature of Personal Representative

_____

Print Name

_____

Date

_____

Description of Personal Representative's Authority