REGISTRATION FORM

SOCIAL SECURITY # _____ DATE: _____

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

BIRTHDATE: _____ AGE: _____ SEX M/F _____ MARITAL STATUS: _____

HOME PHONE: ( )_____ CELL: ( )_____ WORK: ( )_____

EMAIL ADDRESS: _____

HOW DID YOU HEAR ABOUT US? _____

APPOINTMENT REASON: _____

EMPLOYER: _____ POSITION: _____

ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE: _____

PERSON RESPONSIBLE FOR BILL: _____

INSURANCE COMPANY: _____

INSURANCE ID: _____ GROUP: _____

POLICYHOLDERS NAME: _____ SS# _____

GUARANTEE OF PAYMENT: I hearby authorize this provider to furnish information to insurance carriers, imaging centers and other doctor'e offices concerning my illness/injury and treatment at this facility. I hearby assign to this facility, all payments regarding my treatment and any service provided here. I understand that I am responsible financially for all services provided and that billing my insurance does not relieve me of my financial responsibility to this facility. Any scheduled procedure, cancelled by me with less than 72 hours notice will result in my forfeiting any monies pre-paid. I have read the Privacy Policies attached to this registration packet.

Date: _____ Signature: _____

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Date: _____ Signature: _____

AMERICAN SOCIETY OF PLASTIC SURGEONS

Figure 1

Name: _____ Date: _____

SOCIAL

Age: _____ Sex: M ☐ F ☐ Married: Y ☐ N ☐ Occupation: _____

Responsible Adult Available to Assist During Recovery Period Y ☐ N ☐ Relationship: _____

HABITS

Smoke: Y ☐ N ☐ Amount: _____ Coffee/Tea/Cola: Y ☐ N ☐ Amount: _____

Alcohol: Y ☐ N ☐ Amount: _____ Daily Exercise: Y ☐ N ☐ Amount: _____

MEDICATIONS: List dose or number of pills per day

Prescription Drugs

_____

_____

_____

_____

Non-Prescription (Vitamins; Herbs)

_____

_____

_____

_____

Regular Aspirin Use: Y ☐ N ☐ Dosage & frequency: _____

NSA (Advil, Motrin, Ibuprofen): Y ☐ N ☐ Dosage & frequency: _____

Cortisone Injections Past Year: Y ☐ N ☐ Date(s) and injection location: _____

Drug Allergy: Y ☐ N ☐ List drug(s) and type of reaction: _____

_____

Latex Allergy: Y ☐ N ☐ Tape Allergy: Y ☐ N ☐

FAMILY HISTORY:

Have any blood relatives ever had the following problems:

Abnormal Bleeding:	Y ☐ N ☐	Coronary Surgery:	Y ☐ N ☐	Kidney Disease:	Y ☐ N ☐
Abnormal Clotting:	Y ☐ N ☐	Diabetes:	Y ☐ N ☐	Tuberculosis:	Y ☐ N ☐
Anesthetic Problems:	Y ☐ N ☐	Heart Attack:	Y ☐ N ☐	Other Serious Illness:	Y ☐ N ☐
Cancer:	Y ☐ N ☐	Hypertension:	Y ☐ N ☐		

Please describe questions with a "Yes" answer: _____

_____

PERSONAL PAST HISTORY: Have you ever had:

Abnormal Bleeding:	Y ☐ N ☐	Asthma:	Y ☐ N ☐	Hypertension:	Y ☐ N ☐
Abnormal Clotting:	Y ☐ N ☐	Diabetes:	Y ☐ N ☐	Sleep Apnea:	Y ☐ N ☐
Acid Regurgitation:	Y ☐ N ☐	Fainting Spell:	Y ☐ N ☐	Snoring:	Y ☐ N ☐
Anemia:	Y ☐ N ☐	Heart Attack:	Y ☐ N ☐	Weight Change past 12 Mo.:	Y ☐ N ☐
Angina:	Y ☐ N ☐	Hepatitis:	Y ☐ N ☐	Other Serious Illness:	Y ☐ N ☐

Please describe questions with a "Yes" answer: _____

_____

Have you ever received a transfusion? Y ☐ N ☐ If yes, what year? _____

Have you been tested for HIV? Y ☐ N ☐ If yes, what year _____ Test results: ☐ Positive ☐ Negative

Do you wear: Contact lenses: Y ☐ N ☐ Eye glasses: Y ☐ N ☐ Hearing aid: Y ☐ N ☐ Dentures: Y ☐ N ☐

Previous Surgery, year and type of procedure: _____

_____

Indicate the type(s) of anesthesia received in the past, list any complications/reactions you experienced:

☐ Local anesthesia - complications/reactions: _____

☐ General anesthesia - complications/reactions: _____

☐ Spinal / Epidural - complications/reactions: _____

Date last seen by Primary Care Physician: _____

Primary Care Physician (name) _____ (telephone) (_____) _____

(address) _____

WOMEN PATIENTS ONLY:

Number of pregnancies _____ Number of children _____ Last menstrual period _____ Did you breast feed? Y ☐ N ☐