Patient Registration Form

_____ ____/____/_____ ___ M __F
Last Name First Name Middle Initial Today's Date

_____
Home Address: Street City State Zip Code

(_____)_____(_____)_____(_____)_____/_____
Home Phone Number Work Phone Number Cell Phone Number/ Carrier

____/_____/_____ _____ _____
Date of Birth Age Email (Please Print Clearly)

_____
Occupation/Employer Address City State Zip Code

_____(_____)_____
Emergency contact person Relationship Telephone Number

Purpose of Consultation_____ Any previous plastic surgery consults?_____

Any previous plastic surgery? _____Were you satisfied?_____

Who referred you to our office? _____ Friend _____ Family _____ Patient _____ Doctor _____ Website _____ Other

Name of person who referred you (Optional)_____

_____
Name of Spouse

_____
Home Address: Street City State Zip Code

(_____)_____ (_____)_____
Work Phone Number Cell Phone Number

_____
Occupation/Employer

_____(_____)_____
Primary Care Physician Phone

_____ _____
Primary Insurance Policy ID# /Group #

_____
Pharmacy Name Address City/Zip Phone

Patient Medical History

Please complete all questions to the best of your knowledge.

Height_____ Weight_____

Are you being treated by your Primary Care Physician and/or other Specialist for medical conditions? □YES □NO

If yes, please explain:_____

Do you wear contacts? □YES □NO

Are you legally blind? □YES □NO

□ Right Eye □ Left Eye □ Both Eyes

Are you allergic to any medications? □YES □NO

If yes, please explain:_____

Are you currently taking any medications? □YES □NO

If yes, please explain:_____

_____

Are you allergic to latex? □YES □NO

If yes, have you been tested? □YES □NO

Are you currently taking any medications containing aspirin? □YES □NO

If yes, please circle which ones from the following list:

Aspirin Bayer Excedrin Bufferin Ibuprofen Advil Nuprin Motrin Other_____

Are you currently taking any medications for arthritis? □YES □NO

If yes, please list_____

Prior Surgeries? □YES □NO

If yes, please list_____

Any complications with surgery? □YES □NO

If yes, please explain_____

Any complications with anesthesia? □YES □NO

If yes, please explain_____

Any significant illness as a child? □YES □NO

Any significant illness as an adult? □YES □NO

If yes, please explain_____

Any significant illness in your family? □YES □NO

If yes, please explain_____

Do you smoke? □YES □NO

If yes, how many per week? _____ total # of cigarettes/_____ total # of packages

Do you drink alcohol? □YES □NO If yes, how many glasses per week?_____

Have you or anyone in your family ever had a blood clot? □YES □NO
Have you or anyone in your family ever been on blood thinners? □YES □NO
Have your or anyone in your family ever been diagnosed with a blood clotting disorder? □YES □NO
Has anyone in your family had a disease called "purpura fulminanas?" □YES □NO
Have you ever been diagnosed with lupus or any other autoimmune disease? □YES □NO

PLEASE PLACE A (√) NEXT TO ALL THAT APPLY

Airway
□Capped, chipped, broken teeth
□ Unable to open your mouth fully

Respiratory
□ Breathing Problems
□ Sleep Apnea
□ Use breathing devices
□ Asthma, wheezing
□ Tuberculosis
□ Recent cold
□ Used tobacco within the year
□ Persistent Cough
□ Sputum, Phlehm, mucus production
□ Bronchitis, Emphysema, COPD
□ Shortness of breath after walking two flights of stairs

Heart
□ Heart problems/irregularities
□ Leg swelling, edema, CHF
□ High blood pressure
□ Legs cramp while walking
□ Chest pain, angina, MI, heart attack
□ Paralysis
□ Heart murmur, prolapsed mitral valve, rheumatic fever

Skin
□ Problems with wounds healing
□ Bruise easily, excessive bleeding
□ Scar badly
□ Allergic reaction to adhesive tape

Endocrine
□ Diabetes, high or low blood sugar
□ Thyroid problems, heat or cold intolerance

Abdomen
□ Hiatal hernia, frequent regurgitation, heartburn
□ Hepatitis, jaundice
□ Ulcers, vomiting blood
□ Liver disease, cirrhosis
□ Kidney disease

Genitourinary
□ Difficulty passing urine
□ At risk for AIDS or venereal disease
□ Possible you are pregnant

Musculoskeletal
□ Physical limitations, appliances, prostheses
□Arthritis (jaw, neck, back)
□ Phlebitis

Neurological/Psychiatric
□ Seizures, convulsions, fainting, epilepsy
□ Psychiatric treatment
□ Stroke, fleeting blindness, weakness
□ Anxious about possible surgery

General
□ Headaches
□ Steroid use within one year
□ Used recreation drugs within the last year
□ Unexplained weight loss
□ Blood transfusions
□ Anemia
□ Glaucoma
□ Chemotherapy

If you placed a (√) mark in any above the above, please explain:
_____

AUTHORIZATION FOR MEDICAL COMMUNICATION AND PHOTO RELEASE

PLEASE PLACE A (√) NEXT TO ALL THAT APPLY

	Okay to leave voicemail?	Okay to leave message with another person?
□ Call Work Number	□	□
□ Call Cell Phone	□	□
□ Call Home Number	□	□

	Okay for appt Reminder?	Okay for special Offers?
□ Send Email	□	□
□ Send Text	□	□

Photo Limitation: □ Medical □ Office □ Internet Date of Consent: _____

DNR & Advance Directive Policy: Solano Plastic Surgery will acknowledge, file and abide by advance directs and DNR clauses dictated by the patient, within reason of Solano Plastic Surgery policies and procedures. All requests must be in writing and submitted in your patient chart.

ACKNOWLEDGMENT OF PATIENT PRIVACY PRACTICE NOTICE AND PROTECTED HEALTH INFORMATION RELEASE

I have been informed of Solano Plastic Surgery's Patient Privacy Practices. I am aware that this notice describes how protected health information (PHI) about me may be used and disclosed and how I can get access to this information. I have the right to review the Notice of Privacy Practices prior to signing this consent. Solano Plastic Surgery reserves the right to revise its Notice of Privacy Practices at anytime. I have the right to a paper copy of this notice by asking a staff member at the front desk or writing to: Solano Plastic Surgery, 1001 Nut Tree Road, Suite 130, Vacaville, CA 95687.

I am also aware that my Medical Record may be used in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

By signing this form, I am consenting to Solano Plastic Surgery use and disclosure of my PHI.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Solano Plastic Surgery may decline to provide treatment on me.

Solano Plastic Surgery's policy is to maintain the confidentiality of your medical record, also referred to as Protected Health Information (PHI). Our office will not disclose personal or medical information about you unless authorized by you or mandated by law.

As a patient, you have the right to determine who may receive medical information about you from our office. Some patients elect no one other than themselves to receive information while others elect specific family members or friends who may receive their information. In order to assure your PHI continues to be secure, please take a moment to complete the bottom portion of this form.

Please list the first and last name of any individual allowed to receive your PHI. If no one other than you is allowed, please put a check mark in the box next to "self only".

□ Self Only

Name: _____Relationship:_____

Name: _____Relationship:_____

_____ _____

Patient Name (Please print) Date

_____

Signature of patient

If at any time you wish to make a change, please ask us for another form. Thank you!