
Patient Name

Date

Age

Height

Weight

Referring Physician

Primary Care Physician

Preferred Pharmacy

What is the reason for your visit today?

No Known Drug Allergies

Drug Allergies:	

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING INCLUDING OVER THE COUNTER MEDS, TOPICALS, HERBAL SUPPLEMENTS, VITAMINS AND MINERALS.

No Current Medications

Current Medications:	

No Previous Surgical History

Previous Surgeries:	

No Anesthesia Related Complications

Previous Anesthesia Complications:	

Please list all your current medical problems	

Past and Present Medical History

Have you ever had a blood transfusion? Yes No

Have you ever had a reaction to a blood transfusion? Yes No

Do you have prolonged bleeding when cut? (hemophilia) Yes No

Do you have a family history of hemophilia? Yes No

Do you suffer from chronic skin infections? Yes No

Have you ever had MRSA? Yes No

If yes, when and where on your body? _____

Do you have history of hypertrophic or keloid scars? Yes No

Social History:

Non Smoker

- Current Smoker _____ # pks per day _____ # yrs
 Previous Smoker _____ # of yrs. since you quit

Alcohol Use?

- None Occasionally/Socially
 Daily Heavily

History of Drug Abuse?

- None
 Current Recreational Drug User
 Current Narcotics Abuser
 Current Street Drug Abuser
 Previous Narcotics Abuser
 Previous Street Drug Abuser

•• FEMALE PATIENTS PLEASE COMPLETE THE FOLLOWING SECTION••

Have you ever been pregnant? Yes No

Number:	Did you breast feed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Live Births:	How old are your children?
Have you had a mammogram? <input type="checkbox"/> Yes <input type="checkbox"/> No	
When?	
Where?	
Results?	

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

- Masses
 Right Breast
 Left Breast
 Biopsy(ies)
 Right Breast
 Left Breast
 Breast Cancer
 Left Breast
 Right Breast
 Mastectomy
 Lumpectomy
 Radiation Therapy
 Chemotherapy
 Fibrocystic Disease Nipple Discharge
 Skin Lesion(s) Breast Infection(s)
 Breast Pain
 Family History Breast Cancer Who? _____

I attest that the above listed information is true and correct to the best of my knowledge.

 Patient/Guardian Signature

 Date

Patient Name

Date

Age

Height

Weight

Referring Physician

Primary Care Physician

Preferred Pharmacy

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- Current Street Drug Abuser
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 - Radiation Therapy
 - Chemotherapy
- Fibrocystic Disease Nipple Discharge
- Skin Lesion(s) Breast Infection(s)
- Breast Pain
- Family History Breast Cancer Who? _____

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Patient/Guardian Signature

Date

PATIENT AUTHORIZATION

Patient name: _____

DOB: _____

Please initial the following lines. If not applicable, please write N/A on the line.

- _____ I assign Medicare benefits payable to East Texas Plastic Surgery, LLP. I understand that I am responsible for deductible and coinsurance.
- _____ I assign insurance benefits payable to East Texas Plastic Surgery, LLP and I understand that if my insurance company does not pay, that I am financially responsible for payment. I am financially responsible for my deductible and coinsurance.
- _____ I give permission for East Texas Plastic Surgery, LLP to render care that the physician deems medically necessary, such as medical treatment and/or minor surgery.
- _____ I do hereby authorize East Texas Plastic Surgery, LLP to release pertinent information for the following reasons: to physicians for continuing care, to my insurance company or administrator for the processing of claims, and as allowed by law.
- _____ I do hereby authorize East Texas Plastic Surgery, LLP (ETPSLLP), Dr. Gary R. Jacobs and Dr. Philip P. Hawner to use my photographs for the purpose of illustration and/or education. I understand that these photos may be used for the photograph book or the internet. I have been informed that these pictures may be viewed by individuals or groups of individuals in teaching or promotional use; in slide format, publications or electronic media. I understand that these photographs may portray my preoperative appearance, intra-operative surgery or postoperative results. I also understand that no identification will be used with these photographs, but that they may be viewed by persons who will recognize me and be able to identify me.
- _____ East Texas Plastic Surgery, LLP is required by Federal and State law to maintain the confidentiality of your protected health information (PHI). This includes demographic information, as well as diagnosis, treatment plans and results. This law is effective April 14, 2003 and will remain in effect until it is replaced by law or by East Texas Plastic Surgery, LLP. Upon any change, the updated information will become available upon request.

(Patient Signature)

(Date)

(Witness Signature)

(Date)

Patient Name Nickname

Date of Birth Sex: Male Female Social Security Number

Circle: Single Married Divorced Widowed Legally Separated

Home Phone Number Work Phone Number Cell Phone Number Cell Phone Carrier

Email address Referral Source

Address City State Zip code

Employer Name Address City State Zip code

Emergency Contact Name Phone Number

Insurance Company Insurance Company Phone Number

Primary Insurance Company Address City State Zip code

ID Number Group Number

Secondary Insurance Company Insurance Company Phone Number

Insurance Company Address City State Zip code

ID Number Group Number

Responsible Party (Insurance Policy Holder) Responsible Party Date of Birth

Responsible Party Employer Name Address City State Zip code

Occupation

Circle Employment Status: Full-time Student Part-time Student Full-time
Employee Part-time Employee Unemployed Self-Employed Retired

Patient Signature Date

HIPAA DIRECTIVE

The policy of East Texas Plastic Surgery, LLP is to restrict access to a patient's protected health information (PHI). I would like for the following people to have access to my PHI:

<i>Name of person</i>	<i>Date of birth</i>	<i>Relationship</i>	<i>All or Restricted</i>

Restricted information includes: (Please check)

- Sexually Transmitted Diseases Pregnancy
 Terminal illness Mental/behavioral health
 Other _____

Please mark all that apply:

- It is okay to contact me at my home work cell number.
 I prefer that my home work cell number be my primary contact number.
 You may leave a voice message for me at my home work cell number.
 The best time of day to reach me is morning afternoon evenings.
 You may email me an appointment reminder or additional information.
 You may send me an appointment reminder or additional information via a text message.
 You may send me information through the regular mail service.

(Patient signature)

(Date)

(Witness signature)

(Date)

State law permits both parents to have access to PHI unless we are provided with a court order restricting this right.