East Texas Plastic Surgery
Gary R. Jacobs, M.D., F.A.C.S.
703 East Marshall, Suite 4008
Longview, TX 75601
903-753-2276
cosmeticlongview.com

Patient Name: _____

Date of Birth: _____ **Social Security Number:** _____

Patient mailing address: _____

City: _____ **State:** _____ **Zip code:** _____

Home Phone # _____ **Cell #** _____

Email address: _____

Gender: _____ **Marital status:** Single Married Divorced Widowed

Ethnicity - circle one: Hispanic Not hispanic Refused

Race: _____ **Primary language:** _____

Reason for your visit ? _____

Referring Doctor: _____

PCP: _____

Pharmacy name & address: _____

City/State/Zip: _____

List of Medications: _____

_____

Allergies? _____

Emergency information

Emergency contact #1 : _____ Phone #: _____

Relationship to patient: _____

Emergency contact #2 : _____ Phone #: _____

Relationship to patient: _____

Patient/Guardian Signature: _____

Date: _____

EAST TEXAS PLASTIC SURGERY
GARY R. JACOBS, M.D., F.A.C.S.

Patient Name: _____ Date of birth: _____

Patient History - check all that apply

- ☐ Alcoholism
- ☐ Allergies/Hayfever
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Transfusions
- ☐ CAD
- ☐ Cancer
- ☐ Cardiac Pacer
- ☐ Cardiovascular Disease
- ☐ CHF
- ☐ Chicken Pox
- ☐ Cirrhosis
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fracture
- ☐ Gerd
- ☐ Gestational Diabetes
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Myocardial Infarction
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pulmonary Disease
- ☐ Rheumatoid Arthritis
- ☐ Shingles
- ☐ STD
- ☐ TIA
- ☐ Tuberculosis
- ☐ Valvular Problems
- ☐
- ☐

PATIENT SOCIAL HISTORY:

☐ Non Smoker ☐ Current Smoker _____# pks per day for _____# yrs
☐ Prev Smoker _____# of yrs. since you quit _____ Nicotine substitute

Caffeine use: How many cups a day: _____ Caffeinated or Decaf (circle one)
Alcohol Use? ☐ None ☐ Occasionally/Socially ☐ Daily ☐ Heavily
Exercise? How many times per week: _____ Moderate or Strenuous
History of Drug Abuse? Yes or No Which drug(s)? _____

SURGERY (circle all that apply)

Appendectomy
Breast lumpectomy
Breast implant removal/replacement
Cataract
Heart surgery
Laparoscopy
Spleenectomy
Weight loss surgery
Abdominoplasty
Breast mastectomy
Breast reconstruction
Facelift/eyelids
Hernia
Ostomy
Tonsillectomy/Adenoidectomy
Chemotherapy/radiation
Breast augmentation
Breast reduction/lift
Cancer surgery
Gallbladder removal
Hysterectomy
Skin cancer removal
Tubal ligation

PATIENT FAMILY HISTORY:

Mother: _____

Father: _____

Other: _____

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PATIENT HIPAA/authorization

Patient name: _____ DOB: _____

_____ I do hereby assign my insurance benefits payable to: East Texas Plastic Surgery. I understand that if my insurance company does not pay, that I am financially responsible for payment, which includes my deductible and coinsurance.

_____ I give permission for East Texas Plastic Surgery 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 to release pertinent information for the following reasons: to physicians for continuing my care, to my insurance company or administrator for the processing of claims, and as allowed by law.

_____ East Texas Plastic Surgery 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. We will only speak to the person(s) listed as your emergency contact or your referring physician. Should you want to include other people on your HIPAA, please list below.

Name	Date of birth	Relationship to patient

You may contact me and leave appointment information via: (mark all that apply)
_____ Mail _____ Email _____ Phone

I hereby acknowledge that this agreement will remain in force until I notify East Texas Plastic Surgery of any changes.

_____ _____
Patient or guardian signature Date

State law permits both parents of a minor to have access to protected health information, unless we are provided with a court order restricting this right.

This law is effective April 14, 2003 and will remain in effect until it is replaced by law or by East Texas Plastic Surgery. Upon any changes, the updated information will become available upon request.

EAST TEXAS PLASTIC SURGERY
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Female patients only

Patient Name: _____ Date of birth: _____

Have you ever been pregnant? ☐ Yes ☐ No
Did you breast feed? ☐ Yes ☐ No

Current Bra Size: _____ Largest bra size: _____

Have you had a mammogram? ☐ Yes ☐ No
When and where was your mammo: _____

☐ Masses	☐ Left Breast	☐ Right Breast
☐ Biopsy(ies)	☐ Left Breast	☐ Right Breast
☐ Breast Cancer	☐ Left Breast	☐ Right Breast

☐ Family History Breast Cancer - Specify _____

☐ Breast Pain	☐ Left Breast	☐ Right Breast
☐ Mastectomy	☐ Left Breast	☐ Right Breast
☐ Lumpectomy	☐ Left Breast	☐ Right Breast
☐ Radiation	☐ Yes	☐ No
☐ Chemotherapy	☐ Yes	☐ No
☐ Fibrocystic	☐ Left Breast	☐ Right Breast
☐ Nipple Dschg	☐ Left Breast	☐ Right Breast
☐ Skin Lesion(s)	☐ Left Breast	☐ Right Breast
☐ Breast Infection	☐ Left Breast	☐ Right Breast

☐ Previous Breast Implants Saline or Silicone When: _____

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

_____ _____
Patient/Guardian Signature Date