

Welcome



GREGORY P. PISARSKI, MD

Gulf Coast Plastic Surgery

Changing lives, building confidence. One patient at a time.

I would like additional information on:

- | | | |
|--|--|--|
| <input type="checkbox"/> Tummy Tuck | <input type="checkbox"/> Face/Neck Lift | <input type="checkbox"/> Breast Reconstruction |
| <input type="checkbox"/> Liposuction | <input type="checkbox"/> Facial Rejuvenation | <input type="checkbox"/> Breast Augmentation |
| <input type="checkbox"/> Eyelid Surgery | <input type="checkbox"/> Contour ThreadLift | <input type="checkbox"/> Breast Uplift |
| <input type="checkbox"/> Brow Lift | <input type="checkbox"/> Medical Skin Care | <input type="checkbox"/> Breast Reduction |
| <input type="checkbox"/> Nose Correction | <input type="checkbox"/> Spider Vein Injection | <input type="checkbox"/> EpiLight Hair Removal |

PATIENT INFORMATION

Name _____ Date _____
(Last) (First) (M) Mr. Mrs. Miss Dr.

Birthdate ____/____/____ Age _____ Social Security # _____ Sex M F Marital Status _____

Address _____ Drivers license # _____
(Street) (City) (State) (Zip)

HM phone # _____ WK phone # _____ CELL phone # _____

Place of employment (parent if minor) _____ Occupation _____

Family Physician _____ Phone # _____

Email _____ Are you interested in receiving our online newsletter? **Y N**

May we contact you at work? **Y N** Do you wish phone calls to be confidential? **Y N**

FAMILY INFORMATION

Spouse (Parent) Name(s) _____ SS # _____ D.O.B. ____/____/____

Place of employment _____ WK phone # _____

In case of Emergency Contact: _____ Relation to patient _____

Address _____ HM phone # _____
(Street) (City) (State) (Zip)

INSURANCE AND BILLING INFORMATION (ALL BLANKS MUST BE FILLED OUT)

Person responsible for account _____ Relation to patient _____
(If other than self)

Address _____ Phone # _____

PRIMARY INSURANCE _____ ID# _____ Group # _____

Name of Policy Holder _____ Relation to pt _____ SS # _____

Address of Holder _____ Ph # _____ D.O.B. ____/____/____
(If other than self)

SECONDARY INSURANCE _____ ID# _____ Group # _____

Name of Policy Holder _____ Relation to pt _____ SS # _____

Address of Holder _____ Ph # _____ D.O.B. ____/____/____
(If other than self)

How Did You Hear About Our Practice?

____ Physician/Name: _____ Friend/Name: _____

____ Phone Book/ Which One? _____ Ad/Where? _____

PATIENT MEDICAL HISTORY

Name _____ Date _____

PURPOSE OF VISIT _____

Medications (including non prescription) _____

Allergies _____

Do you take *Aspirin* or *Coumadin* daily? Y N Do You Smoke? Y N Do you drink alcohol? Y N

Are you pregnant? Y N Week # _____ # past pregnancies _____ Method of Birth Control _____

Have you had any problems with your health recently? Y N

If yes, what and when: _____

PLEASE CHECK ANY ILLNESSES YOU HAVE OR HAVE HAD:

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Heart Disease / Problems | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Peptic Ulcer Disease | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Reflux | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Vein Problems/Blood Clots | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hay Fever / Allergies |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> VD / HIV / AIDS | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Skin Ulcers | <input type="checkbox"/> Other _____ |

Past Surgeries & Dates _____

Any complications with past surgeries or general anesthesia? Y N

If yes, explain: _____

DO YOU PRESENTLY HAVE OR HAVE YOU EXPERIENCED THE FOLLOWING:

- | | | |
|--|---|---|
| <input type="checkbox"/> Difficulty Breathing / Chest Pain | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Abnormal Bleeding |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Weight Loss / Gain |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Drug / Alcohol Abuse | <input type="checkbox"/> Swelling of Ankles |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Other _____ |

FAMILY MEDICAL HISTORY

Please identify any medical problems **BLOOD RELATIVES** have or have had:

- | | | |
|--|--|--|
| <input type="checkbox"/> Birth / Genetic Defects | <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bone / Joint Disorders | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Seizures / Convulsions |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Heart Disease/Problems | <input type="checkbox"/> Mental Disease/Disorder |
| <input type="checkbox"/> Muscle Disorders | <input type="checkbox"/> Anemia/Blood Disorders | <input type="checkbox"/> VD / HIV / AIDS |
| <input type="checkbox"/> Skin Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Eye / Ear Disorders | <input type="checkbox"/> Kidney Disease/Problems | |