Welcome to GULF COAST PLASTIC SURGERY

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I would like additional information on:

- ☐ Tummy Tuck
- ☐ Smart Liposuction
- ☐ Cellulaze
- ☐ Brow Lift
- ☐ Eyelid Surgery
- ☐ Nose Correction
- ☐ QuickLift/ Face/Neck Lift
- ☐ PrecisionTx LaserLift
- ☐ Breast Augmentation
- ☐ Breast Uplift / Reduction
- ☐ Botox/Dysport
- ☐ Injectable Fillers
- ☐ Vampire Facelift / PRP
- ☐ Fractional Facial Resurfacing
- ☐ Pulsed Light Photofacial

PATIENT INFORMATION

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

Birthdate____/____/____ Age _____ SS #_____Sex M F Ethnicity_____ Marital Status_____

Address_____ _____ D License # _____
(Street) (City) (State) (Zip)

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

Place of employment (parent if minor)_____Occupation _____

Family Physician _____ Phone #_____

Email _____ *May we contact you by email?* **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)

Neighbor or Relative (not living with you) _____ 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 Us? _____

Would you like to be contacted if we need training models for procedures, discounts are substantial? **Y** **N**

PATIENT MEDICAL HISTORY

Name _____ **Date**_____

PURPOSE OF VISIT_____

Medications (including non prescription) _____

_____

Allergies _____

Height _____ Weight _____ Pharmacy _____

Do you take A*spirin* or Co*umadin* daily? [X] [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:

- [ ] High Blood Pressure
- [ ] Heart Disease / Problems
- [ ] Heart Attack
- [ ] Stroke
- [ ] Poor Circulation
- [ ] Vein Problems
- [ ] Anemia
- [ ] Blood Disorders
- [ ] Diabetes
- [ ] Kidney Disorders
- [ ] Pneumonia
- [ ] Emphysema
- [ ] Asthma
- [ ] Peptic Ulcer Disease
- [ ] Reflux
- [ ] Tuberculosis
- [ ] Hepatitis
- [ ] VD / HIV / AIDS
- [ ] Rheumatic Fever
- [ ] Skin Ulcers
- [ ] Lupus
- [ ] Arthritis
- [ ] Gout
- [ ] Polio
- [ ] Epilepsy
- [ ] Cancer
- [ ] Hay Fever / Allergies
- [ ] Mental Illness
- [ ] Seizures
- [ ] 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:

- [ ] Difficulty Breathing / Chest Pain
- [ ] Fainting Spells
- [ ] Fever Blisters
- [ ] Frequent Headaches
- [ ] Persistent Cough
- [ ] Sinus Problems
- [ ] Drug / Alcohol Abuse
- [ ] Psychiatric Problems
- [ ] Abnormal Bleeding
- [ ] Weight Loss / Gain
- [ ] Swelling of Ankles
- [ ] Other _____

FAMILY MEDICAL HISTORY

Please identify any medical problems **BLOOD RELATIVES** have or have had: **Please indicate which family member**

- [ ] Birth / Genetic Defects
- [ ] Asthma
- [ ] Bone / Joint Disorders
- [ ] Rheumatoid Arthritis
- [ ] Muscle Disorders
- [ ] Skin Disease
- [ ] Eye / Ear Disorders
- [ ] Cancer
- [ ] Diabetes
- [ ] Thyroid Disease
- [ ] Heart Disease/Problems
- [ ] Anemia/Blood Disorders
- [ ] High Blood Pressure
- [ ] Kidney Disease/Problems
- [ ] Rheumatic Fever
- [ ] Tuberculosis
- [ ] Seizures / Convulsions
- [ ] Mental Disease/Disorder
- [ ] VD / HIV / AIDS
- [ ] Other_____