Welcome to GULF COAST PLASTIC SURGERY

Gregory P. Pisarski, MD, FACS

I would like additional information on:–

( ) Tummy Tuck	( ) Brow Lift	( ) Botox/Dysport
( ) Smart Liposuction	( ) QuickLift/ Face/Neck Lift	( ) Injectable Fillers
( ) Cellulaze Cellulite	( ) PrecisionTx LaserLift	( ) Vampire Facelift / PRP
( ) Sweat Gland Ablation	( ) Breast Augmentation	( ) ThermiSmooth
( ) Eyelid Surgery	( ) Breast Uplift / Reduction	( ) ThermiVa

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 nonprescription / aspirin) _____

_____

Medication Allergies: _____

Height _____ Weight _____ Pharmacy _____

TOBACCO USE: Do you Smoke Cigarettes? Y N Are you exposed to secondary smoke? Y N

Current: Packs/day _____ # of Years _____ **Past:** Quit Date: _____Packs/day _____ # of Years _____

Other Tobacco (check): ☐ Pipe ☐ Cigar ☐ Snuff ☐ Vape ☐ Nicotine Gum

Do you drink alcohol? Y N # of Drinks/week _____ Do you use marijuana or recreational drugs? Y N

Are you pregnant? Y N # 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	☐ Diabetes	☐ Hepatitis	☐ Epilepsy
☐ Heart Disease/Problems	☐ Kidney Disorders	☐ VD / HIV / AIDS	☐ Cancer
☐ Heart Attack	☐ Pneumonia	☐ Rheumatic Fever	☐ Hay Fever / Allergies
☐ Stroke	☐ Emphysema	☐ Skin Ulcers	☐ Mental Illness
☐ Poor Circulation	☐ Asthma	☐ Lupus	☐ Seizures
☐ Vein Problems	☐ Peptic Ulcer Disease	☐ Arthritis	☐ Thyroid
☐ Anemia	☐ Reflux	☐ Gout	☐ Other
☐ Blood Disorders	☐ Tuberculosis	☐ Polio	_____

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	☐ Fever Blisters	☐ Sinus Problems	☐ Abnormal Bleeding
☐ Chest Pain	☐ Frequent Headaches	☐ Drug / Alcohol Abuse	☐ Weight Loss / Gain
☐ Fainting Spells	☐ Persistent Cough	☐ Psychiatric Problems	☐ Swelling of Ankles

FAMILY MEDICAL HISTORY

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

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