

Welcome to GULF COAST PLASTIC SURGERY

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I would like additional information on:-

- | | | |
|---|--|---|
| <input type="checkbox"/> Tummy Tuck | <input type="checkbox"/> Brow Lift | <input type="checkbox"/> Botox/Dysport |
| <input type="checkbox"/> Smart Liposuction | <input type="checkbox"/> QuickLift/ Face/Neck Lift | <input type="checkbox"/> Injectable Fillers |
| <input type="checkbox"/> Cellulaze Cellulite | <input type="checkbox"/> MyEllevate | <input type="checkbox"/> Vampire Facelift / PRP |
| <input type="checkbox"/> Sweat Gland Ablation | <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Skin Care |
| <input type="checkbox"/> Eyelid Surgery | <input type="checkbox"/> Breast Uplift / Reduction | <input type="checkbox"/> 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:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Disease/Problems | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> VD / HIV / AIDS | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hay Fever / Allergies |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Skin Ulcers | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lupus | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Vein Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blood Clots (DVT/PE) | <input type="checkbox"/> Peptic Ulcer Disease | <input type="checkbox"/> Reflux | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Epilepsy | <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 | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Abnormal Bleeding |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Drug / Alcohol Abuse | <input type="checkbox"/> Weight Loss / Gain |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Swelling of Ankles |

FAMILY MEDICAL HISTORY

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

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