David A. Jansen, M.D. F.A.C.S. | Ravi Tandon, M.D. | John Guste, M.D. | Ruth M. Owens, M.D.

Patient Information ***Date:*****_____**

Name:_____DOB:_____Age:____
Last First MI

Address:_____City:_____State_____Zip_____

Home: (_____)_____Cell (____)_____Work:(____)_____

Can we contact you and or leave a message at these numbers? ☐ YES ☐ NO

SSN:_____Marital Status: _____Email Address:_____

Can we send confidential information to you? ☐ YES ☐ NO

Employer:_____Occupation:_____

_____

Spouse/Emergency Contact information

Name:_____Relationship to Patient:_____

Employer: _____Occupation: _____

Work or Cell Phone: (____)_____

_____

Referring/Primary Care Physician Information

Referring/Primary Physician Name:_____

Address:_____

Phone Number: (____)_____

PLEASE PRESENT DRIVERS LICENSE, IF YOU HAVE INSURANCE AND WOULD LIKE US TO FILE, PLEASE PRESENT YOUR INSURANCE CARD AT CHECK-IN

Primary Insurance Company Name:_____Phone #_____

Secondary Insurance Company Name:_____Phone #_____

PLEASE READ AND SIGN BELOW

I hereby assign payment directly to Surgical Associates, LLC for any medical/surgical procedures performed. I authorize release of information acquired in the course of my examination/treatment as outlined in the Private Policy of this practice. I agree to be responsible for payment of service determine by my insurance carrier as not medically necessary or non-covered service (s). I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. **I further understand and agree that my insurance is filed as a courtesy and that I am ultimately responsible for any balances due after the insurance company has made payment.** I also acknowledge that I have read/understand Surgical Associates, LLC "Notice of Privacy Practices for Protected Health Information" I hereby grant permission for the use of any record, illustration, photograph, or other imaging record created in my case for use in examination, testing, credentialing, and/or certifying purposes by the American Board of Plastic Surgery. Inc.

_____

Patient signature (Parent/Guardian if patient is a minor) **Date**

SURGERY INFORMATION SHEET

NAME:_____AGE:_____

HEIGHT:_____ WEIGHT:_____ BRA SIZE (if applicable)_____

OCCUPATION**:**_____

What area(s) of the face/body are you interested in having improved?_____

_____

MEDICAL EVALUATION
How is your general health? _____

Are you presently being treated for any medical conditions**?**_____

_____

When was your last physical examination ?_____

_____

EYE

Visual loss (one or both eyes)	☐Yes	☐No
"Dry" eyes	☐Yes	☐No
Itching or irritation of eyes	☐Yes	☐No
Blurred or double vision	☐Yes	☐No
Closed or lazy eyes	☐Yes	☐No
Cornea Problems	☐Yes	☐No
Thyroid eye disease	☐Yes	☐No
Wear glasses or contacts	☐Yes	☐No
Previous eye or eyelid surgery (if yes, what type)	☐Yes	☐No

_____

NOSE

Difficult breathing through nose	☐Yes	☐No
Previous injury to nose	☐Yes	☐No
Nasal allergies	☐Yes	☐No
Nose bleeds	☐Yes	☐No
Sinus conditions	☐Yes	☐No
Previous nasal or sinus surgery (if yes, what type)	☐Yes	☐No

_____

FACE

Previous face and neck surgery (if yes, what type)	☐Yes	☐No
Irradiation to face or neck	☐Yes	☐No
Facial paralysis or neck	☐Yes	☐No
Facial skin problems	☐Yes	☐No

CARDIOVASCULAR

Coronary or heart attack	☐Yes	☐No
Congenital heart disease	☐Yes	☐No
Heart murmur	☐Yes	☐No
Palpitations or irregular heart beat	☐Yes	☐No
Hypertension	☐Yes	☐No
Stroke	☐Yes	☐No

CHEST

Shortness of breath	☐Yes	☐No
Chronic lung disease	☐Yes	☐No
Chronic cough	☐Yes	☐No
Asthma	☐Yes	☐No

PSYCHIATRIC

Have you received psychiatric treatment?	☐Yes	☐No
(if yes, were you hospitalized?)	☐Yes	☐No
Has there been any recent crisis in your life?	☐Yes	☐No
Have you ever been treated for drug or alcohol dependency?	☐Yes	☐No

OTHER

History of herpes or fever blisters	☐Yes	☐No
Liver disorder including hepatitis or cirrhosis	☐Yes	☐No
Kidney or bladder disorders or chronic infections	☐Yes	☐No
Spinal or back disorders	☐Yes	☐No
Previous blood clots or thrombophlebitis	☐Yes	☐No
Any bleeding disorders in self or family	☐Yes	☐No
Blood transfusion	☐Yes	☐No
Diabetes	☐Yes	☐No
Autoimmune disease (Lupus, Rheumatoid Arthritis, etc.)	☐Yes	☐No
Any unusual scarring of keloid formation	☐Yes	☐No
If applicable, are you pregnant	☐Yes	☐No

ALLERGIES

Any drug allergies (including local anesthetics and codeine)	☐Yes	☐No
Tape allergies	☐Yes	☐No

If yes, please list drug and reaction type_____

SURGERIES

List any previous surgery

_____

_____

_____

MEDICATIONS

List any medications you are presently taking and dosage (within last month)

_____

_____

_____

Are you taking aspirin? ☐Yes ☐No

Have you taken any steroid preparations over the past year? ☐Yes ☐No

Have you ever used Acutane? ☐Yes ☐No

If so, when was it discontinued? ☐Yes ☐No

SOCIAL

Do you smoke? ☐Yes ☐No

If so, how many packs a day? ☐Yes ☐No

Do you drink more than two drinks per day? ☐Yes ☐No

_____

Signature

List below any questions you would like to have answered during your consultation.

_____

_____

Who referred you to us? _____

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Surgical Associates, LLC and/or Advanced Reconstructive Care, LLC Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Type or Print) Date

_____

Signature

Patient Consent Release Form

I hereby grant permission for the use of any of my medical records including illustration, photographs or other imaging records created in my case, for use in examination, credentialing and or certified purposes by the American Board of Plastic Surgery, Inc.

_____

Patient Signature

_____

Print Patient Name

_____

Witness Signature

_____

Print Witness Signature

_____

Date