VINEYARD PLASTIC SURGERY
PATIENT INFORMATION

Date_____ Referred by_____

Name_____ Family MD _____

Address_____ Pharmacy Phone_____

City_____State___ Zip_____

Phone(H)_____Cell_____ **Spouse or Responsible Party**

Birthdate_____Age____ Name_____

SS#_____ Address_____

E-mail_____ Phone (H)_____(W)_____

Employer_____ Employer_____

Occupation_____

Employer Address_____ If visit due to an injury, please give
Date_____Place_____

City_____State____Zip_____

For an auto accident, please give
Work Phone_____ Insurance co._____
Agent_____
Work-related visit? Yes No

PLEASE HAVE INSURANCE CARDS AVAILABLE SO COPIES CAN BE MADE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
I HEREBY AUTHORIZE VINEYARD PLASTIC SURGERY TO RELEASE ANY AND ALL INFORMATION CONCERNING MY EXAMINATION AND TREATMENT TO THE APPROPRIATE INSURANCE COMPANIES, MY PHYSICIANS AND MY EMPLOYER.

AUTHORIZATION TO PAY PHYSICIAN
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO VINEYARD PLASTIC SURGERY THE MEDICAL/SURGICAL BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO VINEYARD PLASTIC SURGERY FOR CHARGES NOT COVERED BY THIS AUTHORIZATION.

Date_____ Signature_____

MEDICAL INFORMATION

Describe the problem for which you are seeking treatment

_____

_____

_____

Drug allergies_____

Present medications _____

_____

Medical problems (diabetes, hypertension, heart problems, respiratory problems, hepatitis, jaundice, arthritis, sleep apnea)

_____

_____

_____

Previous surgery (include date, doctor, and hospital)

_____

_____

_____

Other hospital admissions/injuries

_____

_____

Anesthetic complications (patient or family) _____

History of blood transfusions/reactions _____

Last tetanus shot _____ Date of last physical examination _____

Height_____ Weight_____ Number of children _____

Cigarette smoker No ☐ Yes ☐ Packs/day_____

History of easy bruising or bleeding? No ☐ Yes ☐ History of leg clots? No ☐ Yes ☐

History of fever blisters or cold sores? No ☐ Yes ☐

Medical conditions that run in family _____

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_____