Date: PLASTIC SURGERY PROFESSIONAL ASSOCIATES REGISTRATION FORM

Name: LAST FIRST MIDDLE

Address:

Birthdate: Age: SS#: E-mail:

Phone #'s Home: Work: Cell:

Please do not write in space below

MEDICAL HISTORY:

Please describe what brings you here

_____
_____
_____
_____

Any **ALLERGIES** or adverse reactions to medications?

Medication:	Reaction:
_____	_____
_____	_____
_____	_____

MEDICATIONS: Please list pills and medicines taken

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST MEDICAL HISTORY: Please list problems or conditions, such as high blood pressure, diabetes, heart problems, asthma, etc. Please describe <u>all</u>:

_____
_____
_____
_____
_____
_____

PREVIOUS SURGERY: Please list type, year, and complications, if any, for each operation

_____
_____
_____
_____
_____

SERIOUS INJURIES: Please list

injury year After effects

_____

_____

_____

SOCIAL HISTORY:

Occupation:_____

Employer: _____

Marital Status:

__Single __Married __Divorced __Separated

__Widowed Number of Children _____

Spouse's Name: _____

Smoking: ___Never ____Stopped in_____
Year

___Yes, ____Packs per day

Alcohol: ___Never ___Occasional ___Regularly

FAMILY HISTORY: Any close family members with similar problems?

_____

_____

_____

GENERAL: Please describe if you answer YES below:

Have you or anyone in your family had problems with anesthesia? ___NO ___YES

_____

_____

Do you or any family members have problems with bleeding? ___NO ___YES

_____

_____

Do you form bad scars or keloids? ___NO ___YES

_____

Have you ever had psychiatric care? ___NO ___YES

_____

Have you seen other plastic surgeons about the same problem which brings you here. ___NO ___ YES

Have you ever had any serious illnesses of the following? (Circle)

Heart	Stomach/bowels	Limbs
Lung	Thyroid	Breast
Liver	Gall Bladder	Eyes
Brain/nervous system		Ears
Urinary	Kidney	Reproductive Organs

_____

_____

_____

_____

Please list any other medical problems or hospitalizations below:

_____

_____

_____

Referred by: Dr._ _____

Address_____

_____

Tel. _____

Primary Physician: _____

Address _____

Tel. _____

Specialists (dermatologist, obgyn, psych., surg, etc)

Dr. _____

Address _____

_____

Tel. _____

Dr. _____

Address _____

_____

Tel. _____

Dr. _____

Address _____

_____

Tel. _____

Name of Financially Responsible Person:

_____

LAST FIRST MIDDLE

Relationship to patient: _____

Address: _____

_____

Phone: _____

Employer: _____

Soc Sec Number: _____

Primary Insurance:

_____

Policy holder:

Name_____

Date of birth _____

Membership/Policy#_____

Group # _____

Address of Insurance Co..

_____

_____

Phone no. of Ins. Co.:_____

Secondary Insurance:

_____

Policy holder's name:

_____

Membership/Policy#_____

_____

Group # _____

Address of Insurance Co. _____

_____

Phone no. of Ins. Co.:

Worker's Compensation

Date of accident: _____

Employer's Name: _____

Contact Person: _____

Phone: _____

Employer's Address

_____

Worker's compensation Insurance

Company:_____

_____

Membership/policy #_____

Group #_____

Ins. Co. Address:

_____

_____

AUTHORIZATION: I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information to requesting parties for the purpose of claims, payment and collections.

In the event my account becomes delinquent, I understand that I am responsible to pay actual and reasonable collection charges, minimum $200, and/or interest up to 18% per annum (1.5% per month) and/or attorney fees.

_____ _____

SIGNATURE DATE

PHOTOGRAPHIC RELEASE: I hereby give permission to Dr. William Kanter and/or Dr. Mitchel Kanter to take still or motion clinical photographs before, during and after surgery or procedures with the understanding that such photographs remain the property of the doctor and his practice. I authorize the doctor(s) and or his associates or designees to utilize such photographs, slides or videos and information as deemed appropriate by the practice to medical or lay groups or individuals, and/or for use on electronic digital networks or websites for publication, advertising, or demonstration. I understand that I shall not be identified by name and shall not receive compensation for the use of these images, but that it is possible I could be recognized from my case history or photographs.

_____ _____

SIGNATURE DATE

PHYSICAL EXAM:

LABS/XRAYS:

IMPRESSION/PLAN: