Smith facial plastics

Patient Information Form

Demographics

Last Name:_____ M.I.:_____ First Name:_____

Preferred Language:_____ Race:_____ Ethnicity:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:( )_____ Cell Phone:( )_____ Cell Carrier:_____

DOB:_____ Age:_____ Gender:_____ SSN:_____

Email Address:_____

Employer Name:_____ Occupation:_____

Address:_____ City:_____ State:_____ Zip:_____

Work Phone:( )_____ Ext:_____ Fax:( )_____

Who is your primary care physician?_____

How did you hear about our clinic?

☐ Dr. Referral:_____ ☐ Word of Mouth

☐ Medical Professional:_____ ☐ Google

☐ Friend:_____ ☐ Advertisement in Media

☐ Other:_____

What is the nature of your visit?_____

Emergency Contact

Name:_____ Relationship:_____

Home Phone:( )_____ Work Phone:( )_____Cell Phone:( )_____

Primary Insurance

Insurance Name:_____ Policy#:_____ Group#:_____

Address:_____ City:_____ State:_____ Zip:_____

****IF YOU ARE NOT THE POLICY HOLDER *PLEASE* FILL OUT BELOW!**

Policy Holder's Name:_____ Relationship to patient:_____

Policy Holder's DOB:_____ Policy Holder's SSN:_____ Phone#:( )_____

Address:_____ City:_____ State:_____ Zip:_____

Secondary Insurance

Insurance Name:_____ Policy#:_____ Group#:_____

Address:_____ City:_____ State:_____ Zip:_____

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Pharmacy

Pharmacy Name:_____ Phone Number:( )_____

Address:_____ City:_____ State:_____ Zip:_____

Section I: Surgery and Anesthesia History

Have you ever had surgery? ☐ No ☐ Yes, please describe:

_____

_____

_____

Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

_____

_____

_____

Section II: Specific Medical History

Are you pregnant? ☐ No ☐ Yes Height: _____ Weight: _____

Have you had or do you currently have the following illnesses:	No	Yes	Description
Asthma	☐	☐	_____
Diabetes	☐	☐	_____
Emphysema	☐	☐	_____
Epilepsy or Seizures	☐	☐	_____
Heart Trouble	☐	☐	_____
Hepatitis or Liver Trouble	☐	☐	_____
Hypertension (High Blood Pressure)	☐	☐	_____
Kidney Trouble	☐	☐	_____
Problem Scarring	☐	☐	_____
Stroke	☐	☐	_____
Thyroid Problems	☐	☐	_____
Have you been advised to or had psychiatric care?	☐	☐	_____

Others Not Listed: _____

Section III: Social History

Do you smoke? ☐ No ☐ Yes, how much? _____

If "no", have you ever smoked in the past? ☐ No ☐ Yes, how much? _____

Do you drink? ☐ No ☐ Yes, how much? _____

Do you have children? ☐ No ☐ Yes, how many? _____

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Section IV: Family History

Do you have any blood relatives whose had any of the following?	No	Yes	Description
Arthritis	☐	☐	_____
Asthma	☐	☐	_____
Bleeding Tendency	☐	☐	_____
Cancer	☐	☐	_____
Chronic Lung Disease	☐	☐	_____
Convulsions or Fits	☐	☐	_____
Diabetes	☐	☐	_____
Gout	☐	☐	_____
Heart Disease	☐	☐	_____
Hypertension (High Blood Pressure)	☐	☐	_____
Kidney Disease	☐	☐	_____
Leukemia	☐	☐	_____
Mental Illness	☐	☐	_____
Migraine Headaches	☐	☐	_____
Obesity	☐	☐	_____
Repeated Infections	☐	☐	_____
Severe Allergies	☐	☐	_____
Thyroid Trouble	☐	☐	_____
Tuberculosis	☐	☐	_____

Others Not Listed: _____

Section V: Medications & Allergies

Are you taking any medications, vitamins, or herbal supplements? ☐ No ☐ Yes, please list:

_____

_____

_____

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

_____

_____

_____