COSMETIC & RECONSTRUCTIVE PLASTIC SURGERY
PATIENT INFORMATION

Date:_____
Patient Name:_____ **Phone: (hm)**_____
Address:_____ **(cell)**_____
City/State/Zip:_____ **Email Address**_____
Height:_____**ft**_____**in** **Weight:**_____**lbs**
Birthdate:____/_____/_____ **Age:**____ **Sex: Male or Female** **SSN:**_____-_____-_____

Employer:_____ **Phone #:**_____
Occupation:_____

Emergency contact person and phone #:_____

REASON FOR INITIAL VISIT:_____
How did you hear about us?
Self - Friend/Family - Phone Book - Magazine - Newspaper - Internet - Physician
If you found us on the internet, which website did you find us on? Google - Yahoo - Implantinfo.com
Plasticsurgery.org - Loveyourlook.com or other_____
Referring Doctor (name):_____
Address:_____
City/State/Zip:_____ **Phone #:**_____

INSURANCE INFORMATION:
Guarantors Name:_____**Phone #:**_____
Address:_____**City/State/Zip:**_____

Primary Insurance:_____	**Secondary Insurance:**_____
Policy holders Name:_____	**Policy holders name:**_____
ID#:_____	**ID#:**_____
Group #:_____	**Group #:**_____
Address:_____	**Address:**_____
Phone #:_____	**Phone #:**_____
Workers Comp:	
Carrier:_____	**Claim #:**_____
Date of Injury:_____	**Claims Adjuster Name:**_____

AGREEMENT TO PAY MEDICAL EXPENSES

Co-payments are collected at the time of your visits with the doctor. Your insurance company will be billed by a billing service. When you have a personal balance, you will receive a monthly statement. Prompt payment of personal balances is appreciated. If you require special payment arrangements, please call the billing service. I authorize the release of any medical or other information to my medical insurance company necessary to process my claim, authorize services, or coordinate treatment. I request payment of government or insurance benefits directly to Elisa Burgess, M.D.
I understand I am personally responsible for all medical expenses provided by Elisa A. Burgess, M.D., for medical care and treatment. I agree to pay all medical expenses within 30 days of the date I am billed for those expenses, unless other arrangements have been made with Dr. Burgess.

Signed:_____ **Date:**_____
Patient's signature/Guardian Signature

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Please list any allergies: (example: Penicillin, sulfa, iodine, seafood, codeine, anesthesia, tape, eggs)
None_____

Food/Drug	Reaction
_____	_____
_____	_____
_____	_____

Current Medications: (please include herbal supplements or over-the-counter remedies)

Name of drug	Dose (mg)	How often taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History:
Do you have any of the following medical problems? (please circle or add)
Constitutional: Recent unexpected weight loss, change in appetite, problems sleeping, fever, other.
Details:_____
Eyes: Dry eyes, glasses, contacts, vision changes, other.
Details:_____
Ears, Nose, Mouth, Throat: hearing aids, seasonal allergies, nosebleeds, difficulty breathing, previous injury, other.
Details:_____
Cardiovascular: high blood pressure, heart murmur (antibiotics prior to dental procedure), heart attack, irregular heart beat, mitral valve prolapse, other.
Details:_____
Respiratory: pneumonia, asthma, other.
Details:_____
Gastrointestinal, Pancreas, Liver: ulcers, bleeding, chronic diarrhea, abdominal pain, pancreatitis, hepatitis, liver disease, other.
Details:_____
Muskuloskeletal: Carpal tunnel, Joint replacement, Muscle problems, Broken bones, Gout, other.
Details:_____
Renal: kidney problems, urine problems (urinary tract infections), bladder problems, other.
Details.:_____
Skin/Breast: skin rash or problems, acne, accutane use, bronzing solution use, breast cancer/surgery, breast lumps, breast biopsies, breast radiation, lymphnode biopsy, other.
Details:_____
Neurological: seizure, head injury, stroke, neuropathy, nerve disease, headaches, migraines, fainting, other.
Details:_____
Endocrine: thyroid, diabetes, hormonal problems, other
Details:_____
Hematologic/Lymphatic: anemia, bleeding tendencies, bruise easily, coumadin use DVT (deep venous thrombosis) or PE (pulmonary embolism), blood clots, phlebitis, blood disorder, other.
Details:_____
Allergic/Immunologic: anaphylactic reactions, HIV/AIDs, TB(tuberculosis), prolonged or persistent infections, other.
Details:_____
Other: fibromyalgia, depression, anxiety, stress, psychiatric problems, cancer, other
Details:_____

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Please list all surgeries or serious injuries:

Type	Year	Surgeon	City/State

Do you smoke? ___Yes ___No How much?_____
Do you use drugs: ___Yes ___No
Do you use alcohol? ___Yes ___No
If you use drugs or alcohol, what do you use and how often?_____
For women: Are you pregnant? ___Yes ___No ___Maybe

Please list any medical conditions, which seem to run in your family:

Illness	Relationship

Please list any recent illnesses or medical concerns:_____
_____
_____

Have you had any diagnostic tests done? Where? When?
____ X-rays_____
____ Mammogram_____
____ MRI_____
____ EMG_____
____ CT scan_____
____ Ultrasound_____
____ EKG/Stress test_____
____ Other_____

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