

**Patient Information**

Fill in or correct all fields

**Patient's Name**

\_\_\_\_\_

First

Middle

Last

**Address**

\_\_\_\_\_

Street & Apt #

City

State

Zip

**Home Phone**

\_\_\_\_\_

**Cell Phone**

\_\_\_\_\_

**Other Phone**

\_\_\_\_\_

Any restrictions for contacting you? No  Yes

If yes, contact restrictions: \_\_\_\_\_

**Email:**

\_\_\_\_\_

**Drivers License # and State**

\_\_\_\_\_

**Age**

\_\_\_\_\_

**Birthdate**

\_\_\_\_\_

**Gender**

Female

Male

**Marital Status:**

Single

Married to:

\_\_\_\_\_

**Other:**

\_\_\_\_\_

**Patient's Employer**

\_\_\_\_\_

**Occupation**

\_\_\_\_\_

**Work Phone**

\_\_\_\_\_

**Ext:**

\_\_\_\_\_

Is it okay to call you at work?

Yes

No

**Address**

\_\_\_\_\_

Street & Suite #

City

State

Zip

**Responsible Party** (if different from patient):

Name of spouse or parent if Patient is a minor \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Address**

\_\_\_\_\_

**Home Phone**

\_\_\_\_\_

**Emergency Contact**

(Not in your household)

\_\_\_\_\_

Relationship to Patient \_\_\_\_\_

\_\_\_\_\_

**Home Phone**

\_\_\_\_\_

**Cell Phone**

\_\_\_\_\_

**Other Phone**

\_\_\_\_\_

**Reason for today's visit**

\_\_\_\_\_

**How did you hear about Dr. Smart?**

Frisco Style

Plano Profile

McKinney Woman

Southern Vanity

D Beauty

TV News

Salon

Facebook

[www.kensmartmd.com](http://www.kensmartmd.com)

Other: \_\_\_\_\_

Friend/Relative: \_\_\_\_\_

Doctor: \_\_\_\_\_

**Acknowledgement of Receipt of Notice of Privacy Practices**

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

**Payment Policy:** Payment is due in full at the time services are rendered.

**Assignment of Benefits:** I hereby assign all medical and/or surgical benefits to which I am entitled, including private insurance and any other health plans, to Frisco Plastic Surgery, P.A.. I transfer my title of reimbursement from my insurance company to Dr. Smart of Frisco Plastic Surgery, P.A.. I authorize Dr. Smart to bill my insurance company for medically necessary services. I authorize my insurance claim form to be sent via electronic filing. I authorize said assignee to release all information necessary to secure payment. I authorize the release of my medical records or insurance claims to be sent via fax. **Regardless of insurance coverage, I am responsible to pay any and all charges that exceed or that are not covered by insurance.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

**Signature**

\_\_\_\_\_

**Date**

\_\_\_\_\_

6898 Lebanon Rd. Suite 102 , Frisco, TX 75034

Health Information as of \_\_\_\_\_ (enter today's date)  
 (Please Print Legibly & Fill In or Correct All Fields)

<b>Patient:</b>				
DOB	Age	Marital Status	Weight	lbs
What surgery are you considering?			Height	ft in

DO YOU NOW OR HAVE YOU EVER HAD..... ( You must circle an answer for each individual item)

Heart Trouble	Yes	No
Heart Attack	Yes	No
Heart Pain	Yes	No
Palpitation or Irregular Pulse	Yes	No
Extra Heart Beats	Yes	No
Stroke	Yes	No
Hypertension	Yes	No
Blood Pressure Abnormalities	Yes	No
Abnormal EKG	Yes	No
Rheumatic Fever	Yes	No
Dropsy or Heart Failure	Yes	No
Digitalis Treatment	Yes	No
Shortness of Breath	Yes	No
Chest Pain	Yes	No
Asthma	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Tuberculosis	Yes	No
Smokers Cough	Yes	No
Emphysema	Yes	No
Coughing or Spitting of Blood	Yes	No
Hay Fever	Yes	No
Major Allergies	Yes	No
Palsy or Paralysis	Yes	No
Nervous Breakdown	Yes	No
Nervous Disorder	Yes	No
Insomnia	Yes	No
Drug Habit	Yes	No
Self-Destructive Tendencies	Yes	No
Psychiatric Hospitalization or Care	Yes	No
Thyroid Problems	Yes	No
Kidney or Renal Disease	Yes	No
Heart murmur	Yes	No
Piercing other than the ears	Yes	No
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No
Missed or irregular last menstrual period	Yes	No
Family history of cancer, heart trouble, stroke	Yes	No

Glaucoma or Eye Problems	Yes	No
Visual Disturbances	Yes	No
Error in Refraction	Yes	No
Other Eye Problems	Yes	No
Hepatitis	Yes	No
Yellow Jaundice	Yes	No
Gallstones or Gallbladder Trouble	Yes	No
Cirrhosis of the Liver	Yes	No
Alcoholism or Drug Dependency	Yes	No
Esophageal Varices	Yes	No
Frequent Indigestion	Yes	No
Ulcers	Yes	No
Gastritis	Yes	No
Colitis	Yes	No
Problem Constipation	Yes	No
Vomiting Blood	Yes	No
Tarry or Bloody Bowel Movements	Yes	No
Hemorrhoids	Yes	No
Goiter or Thyroid Disorders	Yes	No
Diabetes	Yes	No
Skin Disorders	Yes	No
Arthritis	Yes	No
Fracture of Neck or Spine	Yes	No
Bleeding Tendency or Disorder	Yes	No
Abnormal Bleeding after Tooth Extraction	Yes	No
Airway Obstruction (Nasal)	Yes	No
Breast Cysts, Tumors, Abscesses	Yes	No
Nipple Discharge (Apart from Normal Lactation)	Yes	No
Kidney Disorder	Yes	No
Blood Transfusion	Yes	No
Seizures or convulsions or fainting spells	Yes	No
Black outs	Yes	No
Dentures, bridges, capped teeth or crowns	Yes	No
Loose teeth	Yes	No
Cosmetic bonding to teeth	Yes	No
Any family members with bleeding problems	Yes	No
Any family members with anesthesia problems	Yes	No

1. **Please list all present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. **Include over-the-counter medications.**

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2. Do you have an allergic reaction to any medication?  Yes  No Which? \_\_\_\_\_

3. Do you react abnormally to any medication?  Yes  No Which? \_\_\_\_\_
4. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?  
 Yes  No If yes, when and where? \_\_\_\_\_
5. Have you ever been on cortisone or steroid treatment?  Yes  No When? \_\_\_\_\_
6. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?  
 Yes  No If so, how much? \_\_\_\_\_
7. Do you smoke?  Yes  No If so, how much? \_\_\_\_\_ For how long? \_\_\_\_\_
8. Are you pregnant?  Yes  No When was you last normal menstrual period? \_\_\_\_\_
9. How many pregnancies? \_\_\_\_\_ Births? \_\_\_\_\_ Breast Fed?  Yes  No How long? \_\_\_\_\_  
CHILDREN (list names and ages/birthdays): \_\_\_\_\_  
\_\_\_\_\_
10. When was your last physical exam? \_\_\_\_\_ By whom? \_\_\_\_\_
11. When was your last eye examination? \_\_\_\_\_ By whom? \_\_\_\_\_
12. When and where was your last chest x-ray? \_\_\_\_\_ EKG? \_\_\_\_\_
13. Who is your personal physician, if any? \_\_\_\_\_ Please list all physicians presently caring for you.  
\_\_\_\_\_
14. Have you ever been under psychiatric care?  Yes  No When? \_\_\_\_\_ Why? \_\_\_\_\_
15. Have you had any recent blood work done?  Yes  No Where? \_\_\_\_\_
16. Is there anything else you think the doctor should know? \_\_\_\_\_  
\_\_\_\_\_
17. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:  
SURGICAL OPERATIONS (include where, when and why for each surgery): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
HOSPITALIZATIONS (include where, when and why for each admission): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**By signing below, I agree that the above information is complete and accurate to the best of my knowledge.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_