

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 SS# 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)

Home Phone Work Phone Other Phone Relationship to Patient

Reason for today's visit

Due to injury? Injury date: On the job? Auto Accident?

How did you hear about Dr. Smart?

Magazine: Frisco Style Plano Profile Living Southern Vanity Phone Book TV News Salon Web Other: Friend/Relative: Doctor:

Would you like a complimentary skin analysis? No Yes

Insurance: N/A - If Elective Cosmetic Surgery do not need to complete following insurance section.

Primary Health Insurance Company

Name of Insured: DOB Employer Policy # Group # SS# Referral Required? No Yes Copay? No Yes, \$ Ins. Phone

Secondary Health Insurance Company

Name of Insured: DOB Employer Policy # Group # SS# Referral Required? No Yes Copay? No Yes, \$ Ins. Phone

ASSIGNMENT OF RIGHTS AND BENEFITS: I understand that office visit charges are payable on the day service is rendered. 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. I transfer my title of reimbursement from my insurance company to Dr. Smart of Frisco Plastic Surgery. 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

4401 Coit Road, Suite 309, Frisco, TX 75035

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

Patient:				
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	Glaucoma or Eye Problems	Yes	No
Heart Attack	Yes	No	Visual Disturbances	Yes	No
Heart Pain	Yes	No	Error in Refraction	Yes	No
Palpitation or Irregular Pulse	Yes	No	Other Eye Problems	Yes	No
Extra Heart Beats	Yes	No	Hepatitis	Yes	No
Stroke	Yes	No	Yellow Jaundice	Yes	No
Hypertension	Yes	No	Gallstones or Gallbladder Trouble	Yes	No
Blood Pressure Abnormalities	Yes	No	Cirrhosis of the Liver	Yes	No
Abnormal EKG	Yes	No	Alcoholism or Drug Dependency	Yes	No
Rheumatic Fever	Yes	No	Esophageal Varices	Yes	No
Dropsy or Heart Failure	Yes	No	Frequent Indigestion	Yes	No
Digitalis Treatment	Yes	No	Ulcers	Yes	No
Shortness of Breath	Yes	No	Gastritis	Yes	No
Chest Pain	Yes	No	Colitis	Yes	No
Asthma	Yes	No	Problem Constipation	Yes	No
Bronchitis	Yes	No	Vomiting Blood	Yes	No
Pneumonia	Yes	No	Tarry or Bloody Bowel Movements	Yes	No
Tuberculosis	Yes	No	Hemorrhoids	Yes	No
Smokers Cough	Yes	No	Goiter or Thyroid Disorders	Yes	No
Emphysema	Yes	No	Diabetes	Yes	No
Coughing or Spitting of Blood	Yes	No	Skin Disorders	Yes	No
Hay Fever	Yes	No	Arthritis	Yes	No
Major Allergies	Yes	No	Fracture of Neck or Spine	Yes	No
Palsy or Paralysis	Yes	No	Bleeding Tendency or Disorder	Yes	No
Nervous Breakdown	Yes	No	Abnormal Bleeding after Tooth Extraction	Yes	No
Nervous Disorder	Yes	No	Airway Obstruction (Nasal)	Yes	No
Insomnia	Yes	No	Breast Cysts, Tumors, Abscesses	Yes	No
Drug Habit	Yes	No	Nipple Discharge (Apart from Normal Lactation)	Yes	No
Self-Destructive Tendencies	Yes	No	Kidney Disorder	Yes	No
Psychiatric Hospitalization or Care	Yes	No	Blood Transfusion	Yes	No
Thyroid Problems	Yes	No	Seizures or convulsions or fainting spells	Yes	No
Kidney or Renal Disease	Yes	No	Black outs	Yes	No
Heart murmur	Yes	No	Dentures, bridges, capped teeth or crowns	Yes	No
Piercing other than the ears	Yes	No	Loose teeth	Yes	No
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No	Cosmetic bonding to teeth	Yes	No
Missed or irregular last menstrual period	Yes	No	Any family members with bleeding problems	Yes	No
Family history of cancer, heart trouble, stroke	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.**

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: _____