LAWRENCEVILLE PLASTIC SURGERY
PATIENT INFORMATION

Date_____ Referred by_____

Name_____ Family MD _____

Address_____ Pharmacy Phone_____

City_____State___ Zip_____

Phone(H)_____Cell_____ **Spouse or Responsible Party**

Birthdate_____Age____ Name_____

SS#_____ Address_____

E-mail_____ Phone (H)_____(W)_____

Employer_____ Employer_____

Occupation_____

Employer Address_____ If visit due to an injury, please give Date_____Place_____

City_____State____Zip_____

Work Phone_____ For an auto accident, please give Insurance co._____ Agent_____

Work-related visit? Yes No

PLEASE HAVE INSURANCE CARDS AVAILABLE SO COPIES CAN BE MADE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
I HEREBY AUTHORIZE LAWRENCEVILLE PLASTIC SURGERY PC TO RELEASE ANY AND ALL INFORMATION CONCERNING MY EXAMINATION AND TREATMENT TO THE APPROPRIATE INSURANCE COMPANIES, MY PHYSICIANS AND MY EMPLOYER.

AUTHORIZATION TO PAY PHYSICIAN
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO LAWRENCEVILLE PLASTIC SURGERY PC THE MEDICAL/SURGICAL BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO LAWRENCEVILLE PLASTIC SURGERY FOR CHARGES NOT COVERED BY THIS AUTHORIZATION.

Date_____ Signature_____

MEDICAL INFORMATION

Describe the problem for which you are seeking treatment

_____

_____

_____

Drug allergies_____

Present medications _____

_____

Medical problems (diabetes, hypertension, heart problems, respiratory problems, hepatitis, jaundice, arthritis) _____

_____

_____

Previous surgery (include date, doctor, and hospital)

_____

_____

_____

Other hospital admissions/injuries

_____

_____

Anesthetic complications (patient or family) _____

History of blood transfusions/reactions _____

Last tetanus shot _____ Date of last physical examination _____

Height_____ Weight_____ Number of children _____

Cigarette smoker No ☐ Yes ☐ Packs/day_____

History of easy bruising or bleeding? No ☐ Yes ☐ History of leg clots? No ☐ Yes ☐

History of fever blisters or cold sores? No ☐ Yes ☐

Medical conditions that run in family _____

_____

_____

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