BISWAS PLASTIC SURGERY

Appointment Date: _____

Reason For Visit: _____

PATIENT IDENTITY

Name: _____

Gender: _____ DOB: _____

Address _____

_____

Phone: _____ Mobile: Yes No

Text Message Reminders: Yes No
Voicemail Reminders/Messages: Yes No

Email Address: _____

BILLING

Billing Status: Insurance Cosmetic-Self Pay

(If using insurance please note your consultation will be billed to your insurance as an office visit, you will be responsible for any copay and or deductible that apply)

Insurance Carrier: _____

Member ID: _____ Group: _____

(Please bring your insurance card and identification with you to your appointment)

Visit Information

Referral Source: _____

Pharmacy Name: _____ Pharmacy Cross Roads _____

List Allergies: _____

Latex Allergy: Yes No Tape Allergy: Yes No

HEALTH HISTORY

List All Medications:

List Past Surgical Procedures:

Height _____ Weight _____

	YES	No
Do you have children? If yes list their ages.	❑	❑
Cancer	❑	❑
Drug Addiction	❑	❑
Frequent Cough	❑	❑
High Cholesterol	❑	❑
Are you pregnant?	❑	❑
Chemotherapy	❑	❑
Fainting Spells/Dizziness	❑	❑
Have you ever been denied a blood donation?	❑	❑
Radiation Treatments	❑	❑
Recent Weight Loss	❑	❑
Tumor or Growths	❑	❑
Glaucoma	❑	❑
Oral Herpes	❑	❑
Artificial Heart Valve	❑	❑
Congenital Heart Disorder	❑	❑
Heart Murmur	❑	❑
Heart Disease/Trouble	❑	❑
Irregular Heartbeat	❑	❑
Mitral Valve Prolapse	❑	❑
Asthma	❑	❑
Emphysema	❑	❑

	YES	No
Tuberculosis	❑	❑
Liver Disease	❑	❑
Stomach/Intestinal Disease	❑	❑
Kidney Problems	❑	❑
Arthritis/Gout	❑	❑
Osteoporosis	❑	❑
Alzheimer's Disease	❑	❑
Epilepsy or Seizures	❑	❑
Body Dysmorphic Disorder	❑	❑
Cortisone Medicine	❑	❑
Hypoglycemia	❑	❑
Thyroid Disease	❑	❑
Anemia	❑	❑
Blood Transfusion	❑	❑
Deep Vein Thrombosis	❑	❑
Hemophilia	❑	❑
Hepatitis B or C	❑	❑
Sickle Cell Disease	❑	❑
Hives or Rash	❑	❑
Swelling of limbs	❑	❑
Dry Eyes	❑	❑
Cold Sores/Fever Blisters	❑	❑
Sinus Trouble	❑	❑
Chest Pains	❑	❑
Heart Attack/Failure	❑	❑
Heart Pacemaker	❑	❑
High Blood Pressure	❑	❑

	YES	No
Low Blood Pressure	❑	❑
Rheumatic Fever	❑	❑
Breathing Problems	❑	❑
Lung Disease	❑	❑
Frequent Diarrhea	❑	❑
Stomach Ulcers	❑	❑
Yellow Jaundice	❑	❑
Renal Dialysis	❑	❑
Artificial Joint(s)	❑	❑
Mammogram - if yes how long ago?	❑	❑
Convulsions	❑	❑
Stroke	❑	❑
Psychiatric Care	❑	❑
Diabetes	❑	❑
Parathyroid Disease	❑	❑
AIDS/HIV Positive	❑	❑
Blood Disease	❑	❑
Bruise Easily	❑	❑
Excessive Bleeding	❑	❑
Hepatitis A	❑	❑
Leukemia	❑	❑
Anaphylaxis	❑	❑
Any Other Illnesses Not Listed If yes please list:	❑	❑

HABITS

❑Smoking ❑Alcohol ❑Drug Use

FAMILY HISTORY

❑Anesthesia Problems ❑Bleeding Problems ❑Other

SIGNATURE

By signing below, I confirm the answers are accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the office of any changes in medical status.

❑ **I agree**

Name: _____

Date: _____

Witness: _____