DOFT

Plastic Surgery

PATIENT INFORMATION

Name:_____ **Age:**_____**DOB**:_____

Sex: ☐ Male ☐ Female **Marital Status**: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse's Name: _____

Home Address:_____**Apt:**_____

City:_____**State:**_____**Zip Code:**_____

Home Telephone:_____**Work Telephone:**_____

Cell Number: _____**Email Address:**_____

You may contact me by: ☐ **Cell** ☐ **Home Phone** ☐ **Mail** ☐ **Email**
Do we have Permission to leave a message on your phone or voicemail ◯ **YES** ◯ **NO**

Social Security#:_____-_____-_____ **Occupation**:_____

Employers Name and Address:_____

Person to contact in case of emergency:

Name:_____**Telephone #:**_____**Relationship:**_____

Referred by:_____

If you were referred by a medical professional please provide the following:

Name:_____

Address:_____

Telephone Number:_____

Primary Care Physician:

Name:_____

Address:_____

Telephone Number:_____

Pharmacy Details:

Name:_____

Address:_____

Telephone Number:_____

Insurance Information (If Applicable)

Primary Insurance:_____

Members ID Number: _____**Group Name:**_____

Primary Subscriber Name:_____**DOB:**_____
(If subscriber is other than the patient)

Person Financially Responsible for Patient

Name:_____**DOB**:_____

Address:_____**Apt:**_____

Home Telephone:_____**Email Address:**_____

I, the undersigned, herby consent to care and treatment now and in the future. In the event that my insurance company is billed, I authorize payment of medical benefits to the physician(s) or supplier pf rendered services. If my insurance company is not billed or if my insurance company fails to pay for services or does not pay the claim in full, I understand that I am responsible for payment of charges for services rendered. I authorize the release of any medical information necessary to process my claim.

Patient's or Guardians Signature:_____

PATIENT MEDICAL HISTORY FORM

Name:_____ **DOB**:_____

Sex: Male ☐ Female ☐ **Height:**_____ **Weigh**t:_____ **Is your weight Stable** Yes ☐ No ☐

Why are you here to see Dr Doft?_____

_____

Medication Information

Please List **ALL** Medical Conditions	Please List **ALL** Medications (Including vitamins and over the counter medicines)
_____	_____
_____	_____
_____	_____

Do you take, Aspirin, Plavix, Coumadin or any other blood thinner: Yes ☐ No ☐

Allergies: Please name any medications you are allergic to and your allergic reaction

Name of Medication	Your Reaction to Medication
_____	_____
_____	_____
_____	_____

Surgical History

Please list **ALL** prior surgical procedures:	Date:
_____	_____
_____	_____
_____	_____

(Please tick all answers either yes or no)

Social History

Do you smoke: No ☐ Yes ☐ If you answered yes how many packs a day?: _____
Do you drink alcohol on a regular basis: No ☐ Yes ☐ If so how much?: _____

Family History

Family History (please tick applicable): Diabetes ☐ Stroke ☐ Heart Disease ☐ Aneurysm ☐ Cancer ☐
Do you or any family member have a history of a bleeding or blood clotting disorder: Yes ☐ No ☐
Have you or a family member ever had difficulty with anesthesia? Yes ☐ No ☐

Medical History

Are you in good health?	Yes ☐ No☐	Have you ever had high blood pressure?	Yes ☐ No☐
Have you had any heart disease?	Yes ☐ No☐	Do you have lung disease or asthma?	Yes ☐ No☐
Do you have sleep apnea?	Yes ☐ No☐	Do you have liver disease or Hepatitis?	Yes ☐ No ☐
Do you have diabetes?	Yes ☐ No☐	Have you had epilepsy or seizures?	Yes ☐ No☐
Do you have thyroid problems?	Yes ☐ No☐	Do you have any history of cancer?	Yes ☐ No☐
Have you had Covid-19?	Yes ☐ No☐	Do you have a history of skin cancer?	Yes ☐ No☐
History of cold sores?	Yes ☐ No☐	Any history of radiation therapy?	Yes ☐ No☐
History of auto-immune diseases?	Yes ☐ No☐	Do you have any history of keloid scarring?	Yes ☐ No☐
History of neurological disorders?	Yes ☐ No☐	Any history of Psychiatric problems?	Yes ☐ No☐

Do you have any blood disorders, anemia, abnormal bleeding? Yes ☐ No☐
Do you have a collagen vascular disease (ie Lupus, Rheumatoid Arthritis, Raynaud,s Disease)? Yes ☐ No☐

HIV Status: Positive ◯
Negative ◯
Unknown ◯

Hepatitis C Status: Positive ◯
Negative ◯
Unknown ◯

WOMEN

Number of pregnancies:___Births:_____C-sections:_____
Are you pregnant? Yes ☐ No☐ Are you taking birth control? Yes ☐ No☐
Are you nursing? Yes ☐ No☐
Date of last mammogram?_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's or Guardian's Signature:_____**Date**: _____

NOTICE OF YOUR LEGAL RIGHTS TO MEDICAL INFORMATION AND PRIVACY

Your medical information in this office is used only in specific instances governed by law. Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), patients have certain legal rights to privacy regarding their healthcare information.

Understand that this information is limited to:

- Communication with other medical providers to conduct plan, and participate in the treatment of your healthcare directly or indirectly in emergency and non-emergency situations.
- Conduct normal healthcare operations from insurance companies.

Your medical information will **not** be used for any other purpose unless this office receives written permission from you.

I have read and understand my Notice of Privacy Rights to Medical Information privacy.

Patient's Name:_____

Relationship to patient: Self or other:_____

Signature:_____ Date:_____