ARC PLASTIC SURGERY
AESTHETIC RECONSTRUCTIVE CENTER

Personal Information

Please complete this form. All information is confidential. Thank You.

Today's Date: _____ **Social Security #**_____

First & Last Name:_____ **Birth Date**: _____ **Age:**_____

Race:_____ **Ethnicity:**_____ **Preferred Language:**_____

Home Address:_____ **City**_____

State_____ **Zip**_____ **E-Mail**_____

Telephone #: Home (_____)_____ Cell (_____)_____ Work (_____)_____

Preferred Language:_____

Preferred method of contact?_____ Would you like to be added to our mailing list?_____

Employer: _____ Occupation: _____

Marital Status: _____Spouse/Significant Other's Name: _____

Spouse's Contact: Cell (_____)_____ Work (_____)_____

Emergency Contact: Name: _____ Phone # (_____)_____

Primary Care Physician: Name: _____ Phone # (_____)_____

Insurance Information: Company _____

Member #_____ Group #_____

Name of Insured _____ Relationship to Patient _____

Insured DOB _____/_____/_____Insured SS# _____-_____-_____ Insured Home Number (_____)_____

Secondary Insurance Information: Company _____

Name of Insured _____ Relationship to Patient _____

Insured DOB _____/_____/_____Insured SS# _____-_____-_____ Insured Home Number (_____)_____

Responsible party (if patient is a minor):

Name: _____ Birth Date: ____/____/____ SS#:_____-_____-_____

Preferred Pharmacy:_____ Phone Number: (_____)_____

How did you hear about our office? _____

Whom may we thank for the referral? _____

Reason for consultation: _____

_____

_____

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History and Physical

Height:_____ **Weight**:_____ **Normal Weight:**_____

Do you have any allergies to medication? (Yes/No) ____

Please List:_____

Reaction:_____

Please list ALL medications and herbal supplements (including vitamins, herbs, sleep aids, etc.)_____

_____

_____

Do you take Aspirin or Ibuprofen on a regular basis?__Yes__No

Do you smoke or use tobacco products? ____ How many per day?____(cigarettes/packs) Number of years?____

If you have stopped smoking when did you quit?_____ mo/years Date you quit:____/____

Tobacco use other than cigarettes?_____

Do you consume alcohol?___ How many drinks containing alcohol per week?____

Do you use recreational drugs?___ Have you ever been treated for drug or alcohol dependency?_____

Are you on a diet pill or diet program now?___ Have you been in the last 3 years?___

Do you exercise?___ How often?_____

Medical History

Do you have or have you ever been treated for: (Y/N)

Malignant hyperthermia?___	Thyroid problems? ____	Mental illness? ____
Autoimmune disorder? ____	Bulimia or anorexia? ____	Drug Dependency? ____
Chronic illness? ____	Hepatitis/Jaundice? ____	Depression? ____
Heart Disease? ____	Ulcers? ____	Lung Disease? ____
Heart attack? ____	Epilepsy/Seizures? ____	Cancer? ____
Stroke? ____	Cold Sores? ____	Serious Accident? ____
High blood pressure? ____	Mitral Valve Prolapse? ____	Sleep apnea? ____
Blood disorder? ____	Kidney problems? ____	CPAP machine? ____
Blood clotting disorder? ____	Shortness of breath? ____	Latex allergies? ____
Anemia? ____	Asthma? ____	Environmental allergies? ___
Diabetes? ____	Emphysema? ____	

Other?_____

If you answered yes to any of the above, please explain: _____

_____

Have you ever received a blood transfusion?_____ Date:_____

Have you ever been diagnosed with:

Tuberculosis?____ Date:_____ HIV?____ Date:_____ Hepatitis?____ Date:_____

Female Patients Only:

Are you pregnant?_____ Are you breastfeeding?_____

Have you ever been treated for:

Abnormal bleeding?_____ How long ago?_____ Anemia?_____ How long ago?_____

Do you use any birth control?_____ What type?_____

Do you have children?_____ Number of pregnancies?_____

Surgical History

PLEASE LIST ALL PREVIOUS SURGERIES (including cosmetic and dental procedures):

Type:_____ Date:_____ Doctor:_____

Type:_____ Date:_____ Doctor:_____

Type:_____ Date:_____ Doctor:_____

Type:_____ Date:_____ Doctor:_____

Type:_____ Date:_____ Doctor:_____

Anesthesia problems?(include nausea/vomiting, slow to wake up or high temperature) _____

_____

Past hospitalizations_____

Please initial the following:

• The above information is current and correct to the best of my knowledge._____

• I authorize the release of my medical records to insurance companies and authorize the release of any medical information necessary to process my insurance claim._____

• I give my permission to be treated by Dr. Jeremy White and his staff now and in the future and assign all benefits directly to Dr. White. I assume full responsibility for my balance regardless of the status of my insurance claim. In the event that my insurance company is billed, I authorize payment of medical benefits to the physician(s) or supplier of rendered services. If my insurance company is not billed or if my insurance company fails to pay for services or does not pay a claim in full, I understand that I am responsible for payment of charges for services rendered._____

• If computer imaging is used in my evaluation, I understand that the alteration is purely for the purpose of illustration and discussion and in no way constitutes an expressed or implied warranty as to my final results and appearance._____

Patient's Name:_____

Signature:_____Date:_____