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:

____

____

_____

____

_____

<u>**History and Physical**</u>

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? ___
Autoimmune disorder? ____
Chronic illness? ____
Heart Disease? ____
Heart attack? ____
Stroke? ____
High blood pressure? ____
Blood disorder? ____
Blood clotting disorder? ____

Anemia? ____
Diabetes? ____
Thyroid problems? ____
Bulimia or anorexia? ____
Hepatitis/Jaundice? ____
Ulcers? ____
Epilepsy/Seizures? ____
Cold Sores? ____
Mitral Valve Prolapse? ____
Kidney problems? ____
Shortness of breath? ____

Asthma? ____
Emphysema? ____
Mental illness? ____
Drug Dependency? ____
Depression? ____
Lung Disease? ____
Cancer? ____
Serious Accident? ____
Sleep apnea? ____
CPAP machine? ____
Latex allergies? ____

Environmental allergies? ___
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._______

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• 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:_________