Richard Ellenbogen M.D.

PERSONAL INFORMATION

Patient Name: _____ Date: _____

Reason for Visit: _____

Date of Birth: ____ /____ /_____ Age: _____ Sex: M / F Married / Single / Divorced

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Employer: _____ Work Phone: (____) _____

Occupation: _____ FAX: (____) _____

Email:_____

Patient Referred By: _____

PAST MEDICAL HISTORY

Prior Plastic Surgeries: _____

Past Medical Illnesses: _____

Are you being treated for any medical conditions (Yes / No)

If yes, please list medical conditions and current treatment:_____

_____

Family History of Illnesses: _____

Current Medications: _____

Medication Allergies: _____ Easy Bruising or Bleeding: (Yes / No)

Personal Physician: _____ Phone: (____) _____

Date of Last Physical Exam: _____ By: _____

Ever Seen a Psychiatrist or Psychologist?: _____ When?: _____

PATIENT HEALTH QUESTIONAIRE

Height: _____ Weight: _____ Recent Weight gain or loss: _____

Recent Chest X-Ray: (Yes / No) Comments: _____
Recent EKG: (Yes / No) Comments: _____
Recent Mammogram: (Yes / No) Comments: _____

Smoking History: (Yes / No) If yes, please give a daily amount: _____
Drink Alcohol: (Yes / No) If yes, please give a daily amount: _____

Have you ever had the history of the following?:

Heart attack, stroke, rheumatic fever..... Y / N
High/Low blood pressure..... Y / N
History of chest pain..... Y / N
Do your ankles swell..... Y / N
Do you get short of breath easily..... Y / N
Asthma..... Y / N
Hives, rashes or skin disorders..... Y / N
Fainting spells or seizes..... Y / N
Diabetes..... Y / N
Hepatitis, jaundice, cirrhosis..... Y / N
Stomach ulcers or heart burn..... Y / N
Arthritis..... Y / N
Kidney problems..... Y / N
Tuberculosis or persistent cough..... Y / N
Coughing up blood..... Y / N
Venereal disease..... Y / N
Emotional disorders..... Y / N
Excessive bleeding with prior surgery..... Y / N
Blood disorders or anemia..... Y / N
Tumors of the mouth, nose or throat..... Y / N

If yes to any of the above, please elaborate:

_____
_____
_____
_____

Are you taking any of the following?:

Antibiotics..... Y / N
Blood thinners..... Y / N
Diet Pills..... Y / N
Steroids, NSAIDS..... Y / N
Aspirin, Motrin..... Y / N
Insulin or
Heart Medicine..... Y / N
Herbal Supplements..... Y / N
Birth Control Pills..... Y / N
Hormone supplements..... Y / N

If yes to any of the above, please list name and dose of medication(s):

_____
_____
_____

Allergies and Sensitivities:

Local Anesthetics..... Y / N
General Anesthetics..... Y / N
Antibiotics (Penicillin)..... Y / N
Barbiturates, Sedatives.... Y / N
Morphine or Codeine..... Y / N
Adhesive Tapes..... Y / N
Latex..... Y / N

Signature of Patient, Parent or Guardian:_____

GUARANTOR INFORMATION

Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Social Security No: _____ Home Phone: (____) _____

Employer: _____ Work Phone: (____) _____

Work Address: _____

In case of an emergency notify: _____

Relationship: _____ Phone: (____) _____

I, the undersigned, represent that all of the information on this form is true and complete to the best of my knowledge and belief and that I accept full financial responsibility for professional medical and surgical services rendered.

Patient / Insured Signature: _____

Print Name: _____

Richard Ellenbogen, M.D.

Services that are performed that are paid with a credit card, debit card or with financing are not eligible for post-care payment challenges. The practice encourages a complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy. Health care regulations concerning patient privacy acts must be honored. Our office will not share your health information with your bank. I agree that this credit, debit card or financing challenge agreement is irrevocable.

_____ _____

Patient signature Date

_____

Print Name

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