

Scott A. Spiro, M.D., F.A.C.S.

Diplomate of the American Board of Plastic Surgery

PATIENT INFORMATION

Today's Date _____

Mr. Miss

Mrs. Ms. Patient's Name _____

Home Address _____

City, State, Zip Code _____

Social Security # _____ Marital Status ____ Married ____ Single ____ Other

Date of Birth _____ Age _____ Home Phone _____

E-Mail Address _____ Cell/Other Phone _____

I consent to being contacted by e-mail regarding upcoming promotions/special events within the office.

Patient's Occupation _____ Employer _____

Business Address _____ Business Phone _____

Spouse's Name _____ Spouse's Occupation _____

Family Internist _____ Phone _____

Internist's Address _____

Patient Referred By _____

Address _____

Has this office treated any member of your family? _____ If yes, whom? _____

PURPOSE OF INITIAL CONSULTATION

Please check the procedure you are interested in:

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Liposuction | <input type="checkbox"/> Brow Lift | <input type="checkbox"/> Breast Reconstruction |
| <input type="checkbox"/> Face Lift | <input type="checkbox"/> Tummy Tuck | <input type="checkbox"/> Breast Reduction |
| <input type="checkbox"/> Eyelid Surgery | <input type="checkbox"/> Ear Surgery | <input type="checkbox"/> Breast Augmentation |
| <input type="checkbox"/> Rhinoplasty | <input type="checkbox"/> Gynecomastia | <input type="checkbox"/> Breast Lift |
| <input type="checkbox"/> Other, please specify _____ | | |

Have you consulted other Physicians, including Plastic Surgeons, regarding this? _____

If Yes, Physician's Name _____

INJURIES

If consultation is related to an injury, date of injury _____

Injury related to: Work MVA Other _____

Have you been previously treated for this injury? _____

Name of Hospital _____ Name of Physician _____

Patient Name _____

PAST MEDICAL HISTORY

Height _____ Weight _____

Any significant weight loss in the past year? _____ Yes _____ No How Much? _____

Have you ever been pregnant? _____ Yes _____ No How many times? _____

Are you pregnant now? _____ Yes _____ No How many children do you have? _____

Are you planning more children? _____ Yes _____ No

When was your last menstrual cycle?Date _____/_____/_____

ALLERGIES (Please list all including drugs, food, seasonal)

MEDICATIONS (Please list all medications, vitamins, and supplements you are currently taking)

Are there any medications you know you have difficulty tolerating (nausea, upset stomach, etc.)?

Do you have a tendency to suffer from motion sickness (cars, airplanes, etc.)? _____ Yes _____ No

When was your last mammogram? _____ Where? _____

When was your most recent physical check-up? _____ Physician Name _____

Did it include an electrocardiogram? _____ Yes _____ No Chest X-Ray? _____ Yes _____ No

PERTINENT PRE-OPERATIVE INFORMATION

Do you smoke? _____ Yes _____ No How much per day? _____

Anyone else in your household smoke? _____ Yes _____ No How much per day? _____

Do you consume alcohol? _____ Yes _____ No How much per week? _____

Caffeine Consumption _____ Coffee _____ Tea How much per day? _____

Other Caffeinated Beverages _____ How much per day? _____

Having you ever reacted badly to being put to sleep for surgery?..... No___ Yes___

Has any member of your family ever reacted badly to being put to sleep for surgery?..... No___ Yes___

Have you required unusually large amount of local anesthetic for medical/dental procedures? No___ Yes___

Have you ever had a reaction to a local anesthetic (Novocaine, etc.)?..... No___ Yes___

Are you allergic to adhesive tape?..... No___ Yes___

Are you allergic to latex?..... No___ Yes___

Are you allergic to suture material such as catgut?..... No___ Yes___

Do you have high blood pressure?..... No___ Yes___

Have you ever had scarlet fever or rheumatic fever?..... No___ Yes___

Do you bleed unusually easily (from cuts, surgery, tooth extraction)?..... No___ Yes___

Do you bruise unusually easily?..... No___ Yes___

Are you a slow or poor healer?..... No___ Yes___

Do you form large scars or keloids?..... No___ Yes___

Do you have skin diseases, hives, eczema, or rash?..... No___ Yes___

Do you have frequent infections or boils?..... No___ Yes___

Have you taken steroid medications, cortisone, or ACTH?..... No___ Yes___

Do you have shortness of breath with walking?..... No___ Yes___

Do you have or have you had any back trouble?..... No___ Yes___

Does your religion prohibit blood transfusions?..... No___ Yes___

Patient Name _____

PERTINENT PRE-OPERATIVE INFORMATION (CONTINUED)

****IMPORTANT**** Do you see a physician on a regular basis for any medical problems? ___ Yes ___ No

If yes, Physician Name _____ Physician's Telephone _____

Please describe medical condition: _____

Have you had any illness or disorders of the following?

- | | | | |
|---------------------------|--------------------|--------------|---------------------------|
| _____ High Blood Pressure | _____ Blood | _____ Ears | _____ Blood Vessels |
| _____ High Cholesterol | _____ Bones/Joints | _____ Liver | _____ Reproductive System |
| _____ Heart Condition | _____ Arms/Legs | _____ Skin | _____ Urinary System |
| _____ Intestines/Bowels | _____ Nose/Throat | _____ Breast | _____ Nervous System |
| _____ Diabetes | _____ Brain | _____ Face | _____ Lungs |

Please Explain _____

Do you have or have you had any significant emotional problems? _____ Yes _____ No

If yes, please explain _____

Have you ever had Psychiatric/Psychological care? _____ Yes _____ No

If yes, please explain _____

PREVIOUS SURGERIES/HOSPITALIZATIONS (Please list all!)

Date	Surgery/Illness	Hospital & Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had significant complications or after-effects from any of these operations? _____ Yes _____ No

If yes, please explain _____

FAMILY HISTORY

Age	State of Health	Has any relative had:
Mother _____	_____	Tuberculosis? ___ No ___ Yes
Father _____	_____	Cancer? ___ No ___ Yes
Brother(s) _____	_____	Diabetes? ___ No ___ Yes
Brother(s) _____	_____	Epilepsy? ___ No ___ Yes
Sisters(s) _____	_____	Heart Disease? ___ No ___ Yes
Sisters(s) _____	_____	High Blood Pressure? ___ No ___ Yes
Children _____	_____	Lung Disease? ___ No ___ Yes
Children _____	_____	Kidney Disease? ___ No ___ Yes
Children _____	_____	Blood or Bleeding Disorder? ___ No ___ Yes
Children _____	_____	Asthma? ___ No ___ Yes
Children _____	_____	Mental Disease? ___ No ___ Yes

Patient Name _____

EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone _____ Work/Other Phone _____

INSURANCE - PRIMARY

Primary Insurance Company _____

Claims Address _____

Telephone Number _____

ID # _____ Group Name/# _____

Subscriber/Insured _____ Subscriber Employer _____

Subscriber Soc Sec # _____ Subscriber Birth Date _____

Relationship of Patient to Subscriber _____

INSURANCE – SECONDARY

Secondary Insurance Company _____

Claims Address _____

Telephone Number _____

ID # _____ Group Name/# _____

Subscriber/Insured _____ Subscriber Employer _____

Subscriber Soc Sec # _____ Subscriber Birth Date _____

Relationship of Patient to Subscriber _____

ASSIGNMENT OF INSURANCE BENEFITS

(To be used only in the event that full payment is not made prior to surgery.)

I, the undersigned, directly assign to Spiro Plastic Surgery, LLC. all surgical and/or medical benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

Patient Signature _____

If patient is under age 18, Signature of Parent/Guardian _____

SCOTT A. SPIRO, M.D., F.A.C.S.
NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT RECEIPT

I acknowledge receipt of the Notice of Privacy Practices, amended September 20, 2006.

Print Patient Name

Signature of Patient/Legal Representative

Date

**AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION (PHI)**

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is also called "protected health information" under HIPAA's Privacy Rule. I understand that if the person or entity receiving this information is not a health plan or health care provider covered by the federal privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

Name of Individual/Company to Whom
Disclosures May Be Made

Protected

Health

Information

Financial

Information

Limitations of Disclosure: Please describe below limitations you would like on the disclosure of your Protected Health Information and/or Financial Information

I understand that I may revoke this permission, in writing, at any time. Revoking permission, however, does not affect previous disclosures that were made with my consent.

Print Patient Name

Signature of Patient/Legal Representative

Date

**AUTHORIZATION TO BE CONTACTED
THROUGH ALTERNATE MEANS**

I hereby request to be contacted through alternate means. I understand that in the course of doing so, my protected health information may be viewed by individuals I did not intend. I understand that I may revoke this request, in writing, at any time. Please describe below the specific means you would like employed, including alternate address, phone numbers, e-mail addresses, etc.

Print Patient Name

Signature of Patient/Legal Representative

Date