



Date: \_\_\_\_\_

Patient's name: \_\_\_\_\_ SS #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Sex: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Occupation: \_\_\_\_\_ Email: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Business Phone: ( ) \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Business Phone: ( ) \_\_\_\_\_

**HEALTH INSURANCE INFORMATION:** Cosmetic patients may give name of insurance company only. Please have your insurance card available for us to photocopy and fill in the information below if you expect insurance to cover non-cosmetic surgery.

Primary Insurance: \_\_\_\_\_ Insurance Co. Phone: ( ) \_\_\_\_\_

Mailing Address for Claims: \_\_\_\_\_

Policy - or - ID#: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_

Policy Holder's DOB: \_\_\_\_\_ Group Name: \_\_\_\_\_ Group #: \_\_\_\_\_

**SECONDARY INSURANCE:**

Secondary Insurance: \_\_\_\_\_ Insurance Co. Phone: ( ) \_\_\_\_\_

Mailing Address for Claims: \_\_\_\_\_

Policy - or - ID#: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_

Policy Holder's DOB: \_\_\_\_\_ Group Name: \_\_\_\_\_ Group #: \_\_\_\_\_

I hereby authorize Columbia Plastic Surgery to submit a claim to my insurance carrier or to Medicare for all the covered services which have been rendered and direct my insurance carrier to issue payment to Columbia Plastic Surgery. I further authorize the release of any medical information needed by the the above to intermediaries to pay an insurance claim. My signature is good for a lifetime of treatment. Columbia Plastic Surgery will not bill your health insurance for cosmetic surgery.

I understand and agree that I am responsible for any amount not covered by my insurance carrier.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**REFERRED BY:**

Doctor: _____	Nurse: _____	Television: _____
Friend: _____	Relative: _____	Radio: _____
Newspaper: _____	Magazine: _____	Website: _____
Yellow Pages: _____	Hospital: _____	Other Internet site: _____
Other: _____	Patient: _____	PlasticSurgery.org: _____

**MEDICAL INFORMATION SHEET:**

**GENERAL MEDICAL EVALUATION:**

Who is your family or general medical doctor?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

How is your general health? \_\_\_\_\_

Are you presently being treated for any medical conditions? yes no

If so, please specify: \_\_\_\_\_

When was your last physical examination? \_\_\_\_\_

By whom? \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

**FEMALES:**

Last menstrual period: \_\_\_\_\_

Are you pregnant? yes no

Have you had a mammogram? yes no

If yes, when and where was your last mammogram? \_\_\_\_\_

Have you had children? yes no

If so, ages: \_\_\_\_\_

**CHEST:**

Coronary or heart attack: yes no

Angina or chest pain: yes no

Congenital heart disease (at birth) yes no

Heart murmur yes no

Rheumatic fever yes no

Palpitations or irregular heart beat yes no

Prolapsing valve yes no

Hypertension (high blood pressure) yes no

Stroke yes no

Shortness of breath yes no

Chronic lung disease yes no

Cough yes no

Asthma yes no

**GENERAL:**

Seizures or epilepsy yes no

Addison's or Adrenal Disorder yes no

Thyroid Disorder yes no

Skin problems such as Psoriasis, etc. yes no

Liver disorder including hepatitis yes no  
or cirrhosis

Gastro-intestinal or digestive disorders yes no

Kidney, bladder disorders or yes no  
chronic infections

Spinal or back disorders yes no

HIV positive yes no

Vision problems yes no

Glaucoma yes no

Dry eyes requiring drops yes no

Hearing problems yes no

Sinus problems or infections yes no

Frequent infections yes no

Previous blood clots or yes no  
thrombophlebitis

Any bleeding disorders in self yes no  
or in family

Blood transfusion yes no

Diabetes yes no

Auto-Immune diseases (lupus, yes no  
rheumatoid arthritis, etc.)

Any unusual healing problems? yes no

Do you form keloids or thick scars yes no

Do you get "cold sores"? yes no

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:**

Any drug allergies (including local anesthetics, antibiotics, or codeine)?      yes      no

If yes, please list drug and reaction type: \_\_\_\_\_

Aspirin or Ibuprofen allergy      yes      no

Tape allergy      yes      no

Are you allergic to Egg, Beef or Soybean Oil?  
yes (circle which ones)      no

Do you have any other Food Allergies? [please list] \_\_\_\_\_ yes      no

Do you have an allergy to latex?      yes      no

Any problems with anesthesia?      yes      no

If yes, please explain: \_\_\_\_\_

**MEDICATIONS:**

Are you taking aspirin or medication containing aspirin?      yes      no

Are you taking any anticoagulants (blood thinners)?      yes      no

Are you taking birth control pills?      yes      no

Have you taken any steroid (cortisone) preparations in the past year?      yes      no

Are you taking multivitamins?      yes      no

Are you taking vitamin E?      yes      no

Are you or have you taken Accutane?      yes      no

Date of your last tetanus shot: \_\_\_\_\_

List any medications you are currently taking or have taken within the last month and the dosage: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PSYCHIATRIC:**

Have you received psychiatric treatment?      yes      no

If yes, were you hospitalized?      yes      no

Has there been any recent crisis in your life?      yes      no

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

\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL:**

Do you smoke?      yes      no

If so, how many packs per day: \_\_\_\_\_

Do you use other tobacco products?      yes      no

If so, what types: \_\_\_\_\_

How often: \_\_\_\_\_

Do you drink more than one drink per day?      yes      no

If yes, how much: \_\_\_\_\_

**FAMILY HISTORY:**

Any medical problems or illnesses in your family?      yes      no

If so, explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

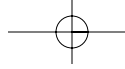
Does anyone in your family have problems with anesthesia?      yes      no

If so, explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does anyone in your family have unusual healing problems?      yes      no

Does anyone in your family have a history of forming keloids or thick scars?      yes      no



**List below any questions you would like to have answered during your consultation:**

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**PREVIOUS SURGERIES:**

Type	Hospital	Surgeon	Date	Complications/difficulties

**PREVIOUS HOSPITALIZATION:**

Type	Hospital	Surgeon	Date	Complications/difficulties

**AUTHORIZATION FOR DISCLOSURE OF INFORMATION**

I authorize John D. Newkirk, M.D. to disclose information concerning his medical findings and treatment, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Dr. Newkirk's determination, are required to receive such information for the purpose of medical treatment, medical quality assurances and peer review. All other requests for information about you will be allowed only with your express written permission or that of your legal guardian.

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

