

**PATIENT REGISTRATION FORM**

**PATIENT INFORMATION**

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

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

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Restrictions for contacting you (circle): Yes  No

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Gender (circle): Male  Female  Transgender  Gender Fluid

Social Security Number: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Marital Status (circle): Single  Married  Other  Spouse/Partner's Name: \_\_\_\_\_

Patient's Employer/School: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Is it okay to call you at work (circle)? Yes  No

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Emergency Contact Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

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

\_\_\_\_\_  
Signature/Guardian Date

## PATIENT REGISTRATION FORM

### SCHEDULING

When you ask us to schedule a surgery for you, we must take several steps to prepare for the day of your surgery:

1. Reserve the operating room.
2. Order and pay for any surgical supplies needed for your surgery.
3. Secure the necessary staff that will be needed, and/or provide coverage to free them up from their other responsibilities.
4. Arrange anesthesia coverage for your case. We must guarantee that we will pay them for this time, whether or not you go through with your procedure.
5. We must turn down every other patient who wants surgery on the day and time we have reserved for you.

Because of these financial obligations and time commitments we must make, we ask that you be certain about your desire for surgery and be positive that you have the funds available before asking us to schedule your surgery.

<b>Health Information</b> (please circle)			
Heart Trouble / Heart Attack / Heart Failure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma or Eye Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Palpitation or Irregular Pulse	Yes <input type="checkbox"/> No <input type="checkbox"/>	Visual Disturbances	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Murmur	Yes <input type="checkbox"/> No <input type="checkbox"/>	Error in Refraction	Yes <input type="checkbox"/> No <input type="checkbox"/>
Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hypertension	Yes <input type="checkbox"/> No <input type="checkbox"/>	Jaundice	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood Pressure Abnormality	Yes <input type="checkbox"/> No <input type="checkbox"/>	Gallstones or Gallbladder Trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>
Abnormal EKG	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cirrhosis of the Liver	Yes <input type="checkbox"/> No <input type="checkbox"/>
Rheumatic Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Alcoholism	Yes <input type="checkbox"/> No <input type="checkbox"/>
Digitalis Treatment	Yes <input type="checkbox"/> No <input type="checkbox"/>	Drug Dependency	Yes <input type="checkbox"/> No <input type="checkbox"/>
Shortness of Breath	Yes <input type="checkbox"/> No <input type="checkbox"/>	Esophageal Varices	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chest Pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Frequent Indigestion	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bronchitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Gastritis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pneumonia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Colitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Constipation	Yes <input type="checkbox"/> No <input type="checkbox"/>
Smoker's Cough	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tarry or Bloody Bowel Movements	Yes <input type="checkbox"/> No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hemorrhoids	Yes <input type="checkbox"/> No <input type="checkbox"/>
Coughing / Spitting / Vomiting of Blood	Yes <input type="checkbox"/> No <input type="checkbox"/>	Goiter or Thyroid Disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hay Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Major Allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>	Skin Disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>
Palsy or Paralysis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Nervous Breakdown	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fracture of Neck or Spine	Yes <input type="checkbox"/> No <input type="checkbox"/>
Nervous Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>	Bleeding Tendency or Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
Insomnia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Missed or Irregular Last Menstrual Period	Yes <input type="checkbox"/> No <input type="checkbox"/>
Drug Habit	Yes <input type="checkbox"/> No <input type="checkbox"/>	Nasal Airway Obstruction	Yes <input type="checkbox"/> No <input type="checkbox"/>
Self-Destructive Tendencies	Yes <input type="checkbox"/> No <input type="checkbox"/>	Breast Cysts / Breast Tumors / Abscesses	Yes <input type="checkbox"/> No <input type="checkbox"/>
Psychiatric Hospitalization or Care	Yes <input type="checkbox"/> No <input type="checkbox"/>	Nipple Discharge (Apart from Normal Lactation)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Thyroid Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
Kidney or Renal Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Blood Transfusion	Yes <input type="checkbox"/> No <input type="checkbox"/>
Piercings (other than ears)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizures / Convulsions / Fainting Spells	Yes <input type="checkbox"/> No <input type="checkbox"/>
Positive Blood Test for HIV / AIDS / Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Black Outs	Yes <input type="checkbox"/> No <input type="checkbox"/>
Family History of Cancer / Heart Trouble / Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Dentures, Bridges, Capped Teeth or Crowns	Yes <input type="checkbox"/> No <input type="checkbox"/>
Family History of Anesthesia Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Loose Teeth	Yes <input type="checkbox"/> No <input type="checkbox"/>
Family History of Bleeding problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cosmetic Bonding to Teeth	Yes <input type="checkbox"/> No <input type="checkbox"/>

**PATIENT REGISTRATION FORM**

**AREAS OF INTEREST** (check all that apply)

<b>FACIAL PROCEDURES</b>	<b>BREAST PROCEDURES</b>	<b>BODY PROCEDURES</b>	<b>IN OFFICE (non-invasive)</b>
<input type="checkbox"/> Laser Resurfacing	<input type="checkbox"/> Breast Augmentation	<input type="checkbox"/> Abdominoplasty	<input type="checkbox"/> Botox/Dysport/Xeomin
<input type="checkbox"/> Blepharoplasty: Eyelid Surgery	<input type="checkbox"/> FTM Top Surgery	<input type="checkbox"/> Panniculectomy	<input type="checkbox"/> Filler Injections: Juvederm, Bellafill, Radiesse, Restylane, Voluma, Belotero, and/or Sculptra
<input type="checkbox"/> Cheek Implants	<input type="checkbox"/> Gynecomastia	<input type="checkbox"/> Brachioplasty: Arm Lift	<input type="checkbox"/> Skin Care
<input type="checkbox"/> Chin Augmentation	<input type="checkbox"/> Breast Implant Exchange	<input type="checkbox"/> Labiaplasty	<input type="checkbox"/> Facial Peel
<input type="checkbox"/> Facelift / Uplyft / LazerLift	<input type="checkbox"/> Breast Reduction	<input type="checkbox"/> Full Body Lift	<input type="checkbox"/> Microneedling
<input type="checkbox"/> Fat Transfers	<input type="checkbox"/> Mastopexy: Breast Lift	<input type="checkbox"/> Thigh Lift	<input type="checkbox"/> SculpSure: Fat Melting Laser
<input type="checkbox"/> Otoplasty: Ear Surgery	<input type="checkbox"/> Nipple Reconstruction	<input type="checkbox"/> Ultrasonic Liposuction/ Body Contouring	<input type="checkbox"/> Vaginal Rejuvenation
<input type="checkbox"/> Brow Lift		<input type="checkbox"/> Smart Lipo	<input type="checkbox"/> Sweet Spot Shot
		<input type="checkbox"/> Cellulaze	<input type="checkbox"/> BioTE: Bio-Identical Hormone Balance for Men and Women
		<input type="checkbox"/> Scar Revision	

**Medical/Surgical History**

Type of Surgery	Date	Purpose (if necessary)

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Medications: (current and that have been used in the last 6 months; including birth control)

Name/Dosage Frequency	Purpose

\*\*\*List all drug allergies\*\*\*:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please answer the following questions (circle and/or explain):

- Drugs such as Suboxone or Methadone can have a lethal effect combined with anesthetic drugs. Do you have a history of or are you currently taking synthetic opioids? Yes  No
- Are you currently being treated for chronic pain? Yes  No   
 Other: \_\_\_\_\_
- Do you smoke? \_\_\_\_\_ Currently  / Previous  / Never   
 How much are/were you using tobacco? \_\_\_\_\_ For how long? \_\_\_\_\_  
 When did you quit? \_\_\_\_\_
- Have you ever been diagnosed with a Latex allergy? Yes  No  Do you react abnormally to medication? Yes  No   
 If so, please list medication(s): \_\_\_\_\_
- Have you or a member of your family ever had any difficulties with any medications, drugs, or gases used for anesthesia (i.e. muscle weakness, jaundice, breathing problems, unexpected fever)? Yes  No   
 If so, when and where? \_\_\_\_\_
- Have you ever been on cortisone or steroid treatment? Yes  No   
 If so, when? \_\_\_\_\_
- Have you ever been under psychiatric care? Yes  No   
 When? \_\_\_\_\_ Why? \_\_\_\_\_
- Have you had any recent blood work done? Yes  No   
 Where? \_\_\_\_\_
- Do you have cocktails regularly, or consume regular amount of alcoholic beverages (including beer, wine, or other alcohol)?  
 Yes  No  If so, how much? \_\_\_\_\_
- Are you pregnant? Yes  No



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11. When was your last menstrual period? \_\_\_\_\_
- a. How many pregnancies? \_\_\_\_\_
- b. Breast fed? Yes  No  If so, how long? \_\_\_\_\_
12. When was your last ...
- a. Physical examination: \_\_\_\_\_  
 By whom? \_\_\_\_\_
- b. Eye exam: \_\_\_\_\_  
 By whom? \_\_\_\_\_
- c. Chest X-ray: \_\_\_\_\_
- d. EKG: \_\_\_\_\_
13. Who is your current Primary Care Physician? \_\_\_\_\_

Please list all physicians presently caring for you:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there anything else that you think the doctor should know?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_