

The Physicians Center
1111 Medical Center Blvd., Suite N406
Marrero, LA 70072
(504) 349-6407
fax (504)349-6407

PATIENT INFORMATION

DATE _____

FULL NAME _____ SEX _____ AGE _____ BIRTHDATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

Marital Status Single (never been married) Married Divorced Widowed

Home Phone # _____ Cell Phone # _____

Social Security # _____ - _____ - _____ E-mail Address _____

Employer _____ Occupation _____

Address _____ Work Phone # _____

City _____ State _____ Zip Code _____

Spouse's Name _____ Spouse's Employer _____ Occupation _____

Address _____ City _____ State _____ Zip Code _____

Children's Names and Ages _____

Any family treated here before? If Yes, name/ relationship/ approx. date _____

Closest local relative or friend not living with you _____

Address _____ Phone # _____

If patient is a minor, please complete this section:

Father's Name _____ Employer _____ Phone # _____

Mother's Name _____ Employer _____ Phone # _____

Person Responsible for Bill (if other than the patient)

Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip code _____

Employer _____ Phone # _____

Address _____ City _____ State _____ Zip Code _____

REFERRAL SOURCE

Friend (Specify) _____

Yellow Pages (Specify) _____

TV or Radio Ad (Specify) _____

Internet _____

Physician (Specify) _____

Seminar _____

Other _____

PERSONAL HISTORY

The requested personal information is necessary part of our evaluation. All information given to us is confidential.

Please list any problems or previous hospitalizations _____

Have you had any serious past illnesses? _____

Please list any accidents or injuries _____

Please list any past surgeries (including minor surgery or surgery as a child) _____

YES	NO	
_____	_____	Do you have any allergies to medications? List medications _____
_____	_____	Do you have any food, environmental, latex allergies? List reactions _____
_____	_____	Are you currently taking any drug or medications? How often? List (include over the counter) _____
_____	_____	Do you take vitamins/ herbal products? List _____
_____	_____	Do you drink more than 6 cups of coffee a day?
_____	_____	Do you drink alcohol? How much? How often? _____
_____	_____	Do you smoke? How much? _____
_____	_____	Do you ever get cold sores or fever blisters? _____
_____	_____	Do you have skin sensitivities, frequent rashes, or eczema?
_____	_____	Have you ever taken Acutane?
_____	_____	Do you have a skin care regimen you follow? Describe _____
_____	_____	Have you ever received local anesthesia? (Novacaine)
_____	_____	Did you have a reaction to anesthesia?
_____	_____	Are you a past/ present carrier of a contagious disease? Please specify _____
_____	_____	Are you or could you be pregnant? _____
_____	_____	Have you taken medicine such as Cortisone or steroid during the past year?
_____	_____	Do you have a personal or a family history of any bleeding or clotting abnormalities?
_____	_____	Do you bleed for more than a half hour after a needle stick?
_____	_____	Do you bleed a day or more after surgery or a tooth extraction?
_____	_____	Do you bruise easily?
_____	_____	Do you bruise without cause?
_____	_____	Do you bruise larger than a half dollar?
_____	_____	Do you bruise from injections?

Date of last physical _____ Date of most recent blood work _____

Date of last chest x-ray _____ Have you had an abnormal chest x-ray? _____

Have you ever had an abnormal EKG? _____

Family Physician _____ Family Physician Phone # _____

Physician Specialty _____

PERSONAL HISTORY

Height _____ Weight _____

DO YOU HAVE OR HAVE YOU EVER HAD: (Please check **ALL** that apply)

YES	NO		YES	NO	
_____	_____	Heart disease or heart trouble	_____	_____	High blood pressure
_____	_____	Lung disease	_____	_____	Liver disease
_____	_____	Kidney disease	_____	_____	Hay fever
_____	_____	Epilepsy/seizures/neurological problems	_____	_____	Chest pain
_____	_____	Thyroid or goiter problems	_____	_____	Chronic cough
_____	_____	Recent respiratory infection	_____	_____	Glaucoma
_____	_____	Skin trouble/infection/rashes/irritations	_____	_____	Phlebitis
_____	_____	Keloid or ugly scars	_____	_____	Fainting
_____	_____	Problems lying flat	_____	_____	Asthma
_____	_____	Nosebleeds	_____	_____	Diabetes
_____	_____	Jaundice	_____	_____	Anemia
_____	_____	Drug or alcohol dependency	_____	_____	Mitral valve collapse
_____	_____	Headache or dizzy spells	_____	_____	Difficulty urinating
_____	_____	Muscle weakness	_____	_____	Hiatal hernia
_____	_____	Ankle swelling	_____	_____	Blood transfusion
_____	_____	Facial fractures	_____	_____	Shortness of breath
_____	_____	Headache or dizzy spells	_____	_____	Are you easily depressed
_____	_____	Back or neck trouble	_____	_____	Ulcers/stomach trouble
_____	_____	Bowel/colon disease or problems			
_____	_____	Do you see eye drops?			
_____	_____	Treatment of genital area			
_____	_____	Are you easily depressed			
_____	_____	Are you on a special diet?			
_____	_____	Recent weight loss (amount) _____			
_____	_____	Any exposure to a communicable disease in the last 3 weeks? Explain _____			
_____	_____	_____			
_____	_____	Have you ever considered seeing a psychologist/therapist?			
_____	_____	Are you seeing a therapist now?			

Do you have any of the following: (Please check **ALL** that apply)

_____ Dentures _____ Partial Plate _____ Bridgework _____ Contacts _____ Hearing aid

Family History: _____ Diabetes _____ Bleeding _____ Heart disease _____ Anesthesia problems _____ Other

Is there anything else you would like us to know?

IN WHICH PROCEDURES ARE YOU INTERESTED

- | | |
|--|---|
| <input type="checkbox"/> Rhinoplasty | <input type="checkbox"/> Removal of facial lesions |
| <input type="checkbox"/> Septoplasty (Correct trouble breathing) | <input type="checkbox"/> Scar revision |
| <input type="checkbox"/> Face/ Neck Lift | <input type="checkbox"/> Laser skin resurfacing |
| <input type="checkbox"/> Eyelid surgery | <input type="checkbox"/> Lip enlargement |
| <input type="checkbox"/> Forehead surgery | <input type="checkbox"/> Lip reduction |
| <input type="checkbox"/> Endoscopic or minimal incision surgery | <input type="checkbox"/> Chemical peel |
| <input type="checkbox"/> Breast surgery (Augmentation) | <input type="checkbox"/> Removal of prominent veins on face |
| <input type="checkbox"/> Breast Uplift | <input type="checkbox"/> Dermabrasion |
| <input type="checkbox"/> Breast reduction | <input type="checkbox"/> Facial Fillers |
| <input type="checkbox"/> Nipple surgery | <input type="checkbox"/> BOTOX |
| <input type="checkbox"/> Abdominoplasty (tummy tuck) | <input type="checkbox"/> Fat Transfer |
| <input type="checkbox"/> Liposuction | <input type="checkbox"/> Lines around lips |
| <input type="checkbox"/> Stomach | <input type="checkbox"/> Lines around eyes |
| <input type="checkbox"/> Thighs | <input type="checkbox"/> Skin Pigmentation |
| <input type="checkbox"/> Hips | <input type="checkbox"/> Chin enlargement |
| <input type="checkbox"/> Ankles | <input type="checkbox"/> Chin reduction |
| <input type="checkbox"/> Knees | <input type="checkbox"/> Other |
| <input type="checkbox"/> Face | |

What specifically do you wish to have changed? _____

When did you begin to consider surgery correction? _____

Have you consulted with any other doctors about this? (When) _____

Have you discussed this surgery with your family? ____ YES ____ NO Are they agreeable? ____ YES ____ NO

Have you had previous cosmetic surgery? _____ YES _____ NO

When was the surgery performed? _____

By Whom? _____

Were you satisfied with the result? _____

If not, why? _____

Have you had any surgery or injury to the area? _____

Describe what and when _____

Has anyone in your family or a close friend had cosmetic or reconstructive surgery? _____

If so, what was done? _____ By whom? _____

INSURANCE INFORMATION

Do you have insurance? _____

Name of insurance company? _____

Name of Policy Holder? _____

ID# _____

Group # _____

Address for Claims _____

Phone # _____ (Please have your insurance card ready to present to the receptionist)

AUTHORIZATION AND ASSIGNMENT OF BENEFITS (Please sign both)

I authorize Gregory W. Pippin, M.D., to furnish information to insurance carriers only concerning my illness and treatments.

Date _____

Signature _____

I assign to Gregory W. Pippin M.D., all payments for medical services rendered to me or my dependent. I understand that I am responsible for any amount not covered by assigning insurance.

Date _____

Signature _____

A photocopy of this authorization and assignment shall be considered as valid as the original.

It is customary to pay for professional services when rendered. Itemized receipts will be furnished on request. Patients are asked to file for routine office visits with their respective insurance companies. In the event of surgery, it is the patient's responsibility to furnish us with the appropriate insurance form on which to file surgery charges. The patient is responsible for all fees, regardless of insurance coverage.

PHOTOGRAPHIC CONSENT

I hereby consent that any and all photographs taken or ordered by Dr. Gregory W. Pippin of any part of my body, whether originals or reproductions, may be utilized for such purpose as he may desire in connection with his research, writing, professional activities, and may be used, exhibited and published through any medium whatsoever as part of or in connection with his research, writing, and professional activities, even though such use may be for advertising purposes or purpose of trade. This consent is not retractable, either by oral or written means and stands for all time until the end of the world.

I certify that I have read and understand the aforementioned and signed my name below giving consent to the foregoing and any photographs taken for future surgeries.

Patient's Signature _____ Date _____

Witness By _____ Date _____