MEDICAL /HISTORY REGISTRATION FORM

Date: _______________ Sex M☐ F☐

Patient Name:_______________________________________

Address: ____

City: ________________ State: ______ Zip: _____________

DOB:_______________ SS#: __________________________

PH#: ____________________ Cell: ____________________

May we leave a message? ☐ **Yes** ☐ **No**

Email address: _______________________________________

Name of Employer: ________________________________

☐Married ☐ Single ☐ Divorced ☐ Widowed

Spouse Name: _________________________________

In Case of Emergency, Contact:

Name: ____

Home Ph#: ____

Cell: ____________________ Work: ___________________

How Did you hear about us? _________________________

Insurance Information

(If this is cosmetic, please disregard this section)

Insurance Co: ____

Policy#: ____________________GP#: ____________________

PH#: ____

Name of Insured: ______________________________________

Relationship to Patient: _________________________________

DOB:__________________ SS#: _________________________

Secondary Insurance: _________________________________

Policy#: _____________________ GP#: ___________________

PH#:____

Name of Insured: _____________________________________

DOB: ______________ ___SS#: __________________________

Who is Responsible for this account?

____

Signature

Insurance Assignment And Release

I certify that I have insurance coverage with ________________________________ and assign direct payment to **Webb Aesthetic Plastic Surgery, PA** for insurance benefits on services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named practice may use of my health care information and may disclose such information to the above-named insurance company(ies) and the agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

Medicare Authorization

I request that payment of authorized Medicare benefits and, if applicable Medigap benefits, be made on my behalf to **Webb Aesthetic Plastic Surgery, PA** for service furnished to me by that provider.

____ **_______________________**

Signature of Patient, Parent or Guardian **Date**

PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY:

MEDICAL /HISTORY REGISTRATION FORM

General
- ☐ Chills
- ☐ Depression
- ☐ Stress
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Headaches
- ☐ Loss of Sleep
- ☐ Numbness
- ☐ Sweats
- ☐ Seasonal Allergies
- ☐ Any complications with sexual function

Muscle/Joint/Bone Pain, weakness, numbness
- ☐ Arm ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

Genito-Urinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Kidney Stones

Gastrointestinal
- ☐ Poor Appetite
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Cardiovascular/Lungs
- ☐ Chest pain
- ☐ High ☐ Low blood pressure
- ☐ Irregular/rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins
- ☐ Coughing
- ☐ Wheezing

Eyes,Ears,Nose, Throat
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision- Flashes/Haloes

Skin
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal
- ☐ Keloids

Women Only
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast Lump
- ☐ Extreme menstrual pain
- ☐ Nipple discharge
- ☐ Other___________________

Date of last menstrual period

____

Date of last Pap smear

____

Date of last mammogram:____________

Abnormal Mammogram Results:
☐ Yes ☐ No

Where was your Mammogram performed? ________________

Are you Pregnant?
☐ Yes ☐ No

Check conditions you have or have had in the past

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ COPD
- ☐ Intestinal Disease
- ☐ Heart Attack
- ☐ Diabetes
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Hepatitis
  - ☐ A ☐ B ☐ C
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Gall Bladder Disease
- ☐ Pace Maker
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headache
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Ulcers
- ☐ Lupus or Other Connective Tissue Disease
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Veneral Disease
- ☐ Bleeding Disorders/ Clotting Disorder (IE: Factor V Leiden, Von Willebrand Disease)

FAMILY HISTORY

Date of last Physical Exam: __________ **Primary Physicians Name:** _________________ **Physicians Ph #:**________________

MEDICAL /HISTORY REGISTRATION FORM

Father ☐ Deceased ☐ Alive **Mother** ☐ Deceased ☐ Alive **Siblings** ☐ Deceased ☐ Alive

Cause of Death: _____________ Cause of Death: _____________ Cause of Death: _____________

Other family history: (Distant Relatives): ____

Please list any surgeries you have had: ____

____

HAVE YOU EVER EXPERIENCED ANY REACTION FROM ANESTHESIA: ☐ Yes ☐ No

If yes, Please Explain: ____

Medication/ Allergies

List medications you are currently taking: (or you may provide a list)

____

____

____

Pharmacy Name: _________________________ Street, City: _____________________ Ph#: ________________________

Are you allergic to any medications or substances?

____

____

Health Habits

Check which ones you use and how much:

☐ Caffeine: ________________________ ☐ Tobacco: _____________________ ☐ Alcohol: _____________________

☐ Street drugs: _____________________ ☐ Other: ________________________ ☐ Exercise: ____________________

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in my/child health or insurance information.

____ ____________________________

Signature of Patient, Parent or Guardian Date

____

Relationship to Patient