

**Our Board Certified Plastic Surgeons perform all types of Facial and Body COMETIC SURGERY**

*Breast Augment Liposuction Facelift Tummy Tuck Eyelid Enhancement*

*Breast Lift Botox Injectable Fillers And Others*

**In addition to this we also provide services through our Skin Care Specialists:**

*Micropeel Laser Hair Removal Micropigmentation*

**If you wish information or a brochure please ask our staff or your physician.**

PATIENT REGISTRATION

PLEASE PRINT

DATE: \_\_\_\_\_

Patient Name \_\_\_\_\_ Age \_\_\_\_\_

LAST FIRST MIDDLE

Address \_\_\_\_\_ Social Security Number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_

Employment \_\_\_\_\_ Work Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ Referring Doctor \_\_\_\_\_

Whom may we thank for referring you? (please check)  Family  Friend  Another doctor  TriHealth Pavilion  Newspaper

Internet  Our WebPage  Television  Yellow Pages  Other \_\_\_\_\_

Reason for seeing Doctor today: \_\_\_\_\_

Have you seen other plastic surgeons about the SAME problem: \_\_\_\_\_

RESPONSIBLE PARTY NAME \_\_\_\_\_ Relation \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Employment \_\_\_\_\_ Work Phone \_\_\_\_\_

PERSON TO NOTIFY IN CASE OF EMERGENCY:

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

PRIMARY INSURANCE COMPANY \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Subscriber Sex \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_\_

Identification Number \_\_\_\_\_ Group Number \_\_\_\_\_ Code \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

SECONDARY INSURANCE COMPANY \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Subscriber Sex \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_\_

Identification Number \_\_\_\_\_ Group Number \_\_\_\_\_ Code \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

I hereby assign all medical and/or surgical benefits to which I am entitled to the physician(s) of Cincinnati Institute of Plastic Surgery. This assignment will remain in effect until revoked by me in writing. I also authorize the release of any information regarding services rendered to secure payment from insurance. A photocopy of this signature is to be considered as valid as an original. In the event insurance should deny payment for any or all of the services rendered, I agree to be personally and fully responsible for payment.

Signed \_\_\_\_\_ Date \_\_\_\_\_

## History and Physical

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

Do you smoke? YES NO If Yes, how much? \_\_\_\_\_

Are you Latex sensitive? YES NO Do you drink alcohol? \_\_\_\_\_

Do you have any Allergies—i.e. pills, drugs, medicine, paper tape, etc. YES NO

If yes, comment \_\_\_\_\_

Please list ALL medications you are now taking including vitamins \_\_\_\_\_

Have you ever had a problem with GENERAL anesthetic? (being put to sleep) YES NO

Have you ever had a problem with LOCAL anesthetic? (example: novocaine, etc.) YES NO

### HAVE YOU EVER HAD:

High blood pressure	YES	NO	Blood disease	YES	NO
Heart disease	YES	NO	Blood transfusion	YES	NO
Lung disease	YES	NO	Blood clots	YES	NO
Kidney disease	YES	NO	Hepatitis and/or liver disease	YES	NO
Diabetes	YES	NO	HIV	YES	NO
Stroke or Seizure	YES	NO	Depression or other psychiatric illness	YES	NO
Heavy scars	YES	NO	Frequent infections or boils	YES	NO

### FEMALES ONLY

How many times have you been pregnant \_\_\_\_\_ How many children do you have \_\_\_\_\_

Are you pregnant now? YES NO Are you nursing now? YES NO

Do you have a history of breast cancer or other breast diseases? YES NO

Have you had an abnormal mammogram? YES NO

For Breast Surgery patients, what is your current Bra size \_\_\_\_\_

### Please LIST Previous Surgery

Operation	Year	Complications, if any
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### NEWSLETTER

We would love to stay in touch with you and bring you the most recent information regarding Plastic Surgery and Skincare in a **free** and **confidential** newsletter. We will not share or sell any of your information and you may remove your address at anytime. The newsletter will be sent out monthly via e-mail.

May we send you our newsletter? YES NO E-mail address: \_\_\_\_\_

### Patient Photographic Release

I understand and accept that I may be recognized from my likeness or case history. Nevertheless, I authorize my plastic surgeon to use my photographs, videotapes, and case information in educational and scientific settings including lectures and multimedia presentations for an audience of medical professionals, at which members of the press may be present and medical, surgical and scientific journal articles. I authorize the use of photographs, videotapes and case information in the following commercial/educational settings; my surgeon's office patient educational material; my surgeon's file of pre- and postoperative patient photographs available to prospective patients for viewing in the office; newspaper and magazine articles in which my surgeon participates; television programs in which my surgeon participates; my surgeon's personal web site or web page; and lectures and multimedia presentations given by my surgeon for general public.

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