JOHN J. HEIECK, M.D., FACS
JOHN J. EDNEY, M.D., FACS
RICHARD J. BRUNETEAU, M.D., FACS
MARIE E. MONTAG, M.D., FACS

Aesthetic
SURGICAL IMAGES
SPECIALISTS IN THE ART & SCIENCE OF COSMETIC SURGERY

Patient Information Front & Back Side

Patient's Name (First, Middle Int., Last) _____

Title (please circle one) Mrs. Ms. Mr. Dr. Preferred Name if different than first: _____ Male □ Female □

Date of Birth_____ Social Security Number _____Height _____ft_____inches

Street Address _____ Apt. # _____ Weight_____lbs.

City _____ State _____ Zip _____

Present Employer _____ Position _____

Home Phone (__)_____ Work (___)_____ Cell (___)_____

E-Mail _____ Marital Status _____

Referring Physician _____City, State _____

In Case of Emergency (*required)

Spouse's or Parent's Name(s) _____Relation to Patient _____

Home Phone (__) _____ Cell Phone (__) _____

Present Employer _____ Work Phone (___) _____

Health Insurance Information

In effort to better serve our patients, we ask you complete the following information. This information will expedite prompt settlement on any insurance claims filed.

Is the condition for which you are being treated due to an accident? □ Yes □ No If so, please give date _____

If your injury is due to a motor vehicle accident or personal injury (i.e.: dog bite, fall, etc.), please complete the following:

Name of Insurance Company or Attorney: _____

Street Address _____ Suite # _____

City _____State _____ Zip_____

Is this worker's compensation □ Yes □ No

Primary Insurance Company _____

Name of Policy Holder _____DOB _____Relationship to Patient_____

Identification Number _____Group Number _____

Secondary Insurance Company _____

Name of Policy Holder _____ DOB _____Relationship to Patient _____

Identification Number _____Group Number _____

I request payment of authorized insurance benefits be made directly to Aesthetic Surgical Images, P.C. for service rendered to myself or my dependent. I further authorize and direct Aesthetic Surgical Images, P.C. to furnish to my insurance company all information needed to determine benefits payable for services rendered. I understand that I am responsible for all services not covered by my insurance company.

Signature of Patient _____ **Date** _____

(or legal guardian)

Health Information

Full name of ***primary care physician*** _____Phone number (___) _____

My last physical examination was _____

List any hospitalizations or illnesses within the last year_____

_____

Yes	***No***	
□	□	Do you accept the fact that there are medical risks involved in every medical and surgical environment?
□	□	Personal or household member history of **MRSA**?
□	□	Do you have a history of **blood clots**? Medication _____
□	□	Have you ever had abnormal bleeding?
□	□	Do you have a **latex allergy?**
□	□	Do you have diabetes? Medication _____
□	□	Do you smoke? How much? (Please be honest)
□	□	Have you ever been diagnosed or treated for TB (Tuberculosis)?
□	□	Do you usually have two or more alcoholic drinks a day?
□	□	Have you ever been under the care of a psychiatrist or psychologist? Name of doctor _____When and Why_____
□	□	Have you ever taken Accutane? When? _____
□	□	Do you have hepatitis, jaundice, or liver disease?
□	□	Do you have a sexually transmitted disease?
□	□	Have you had exposure to HIV?
□	□	Do you have excessive scarring?
□	□	Do you experience poor wound healing?
□	□	Do you have a pace maker? Please explain _____
□	□	Do you have allergies to eggs or soybeans?
□	□	Do you have difficulty with anesthesia? Please explain _____
□	□	Do you have high fevers (malignant hyperthermia) during or after general anesthesia? (This also includes immediate family members)
□	□	Do you have any allergies to local anesthesia? Please explain _____
□	□	Are you taking any herbal medicines? St. John's Wort Garlic Ginko Fever Few Vitamin E Other
□	□	Are you taking any diet pills? Redux Phen-Fen Other
□	□	Do you have any **drug allergies**? Please list _____

List current medications _____

□	□	Are you, or do you think you might be pregnant?

___ /___ Number of pregnancies/deliveries

What is the primary reason for your visit today? _____

How were you referred to Aesthetic Surgical Images? *(If by physician, please be specific)* _____