BROWN
PLASTIC SURGERY

Patient Information Form

Today's Date: _____

Name (First):_____ (M.I.): _____ (Last): _____

Address: _____City:_____State:_____Zip:_____

SS#: _____ Date of Birth: _____ Age: _____ Gender: Male Female

Marital Status: Single Married Widowed Other Spouse/Partner Name: _____

Home Tel: _____ Work Tel: _____Mobile Tel:_____

E-mail: _____ May we contact you by e-mail? ☐YES ☐NO
May we use your e-mail for medical related correspondence? ☐YES ☐NO

Preferred Contact Method (Circle): Home Phone Work Phone Cell Phone

Ok to leave a message on home phone? ☐ YES ☐ NO Ok to leave a message on cell phone? ☐ YES ☐ NO

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Reason For Visit: _____

REFERRAL SOURCE: HOW DID YOU HEAR ABOUT DR. RICHARD J. BROWN, MD

Website: ☐Google ☐ RealSelf ☐Yelp ☐ Facebook☐ Instagram

Other Website: _____ Internet Keywords Used: _____

Doctor/ Insurance Referral: _____ Patient Referral: _____

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, siblings or children to call and request/receive medical and/or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical and/or billing information released to a family member you must sign this form. Signing this form will only give consent to release this information to the family members indicated below. This consent form will not allow Richard J. Brown MD to release any other information to these family members. You have the right to revoke this consent at any time in writing.

I authorize/allow Richard J. Brown and/or his staff to release my medical and/or billing information to the following individual(s):

1. Name: _____ Phone: _____ Relationship: _____
2. Name: _____ Phone: _____ Relationship: _____
3. Name: _____ Phone: _____ Relationship: _____

Patient Signature: _____ Date: _____

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Patient Health History

Patient Name: _____ Height: _____ Weight: _____

Past Medical History	Family History	Afflicted Family Member
☐ Denies Past Medical History	☐ No Relevant Family History	
☐ Emphysema	☐ Unknown - Adopted	
☐ Asthma	☐ Autoimmune Disorders	
☐ Breast Cancer	☐ Breast Cancer	
☐ Cancer (Other)	☐ Colon Cancer	
☐ Heart Attack	☐ Diabetes	
☐ Diabetes	☐ Glaucoma	
☐ Seizure Disorder	☐ Heart Disease	
☐ Heart Disease	☐ High Blood Pressure	
☐ Heart Murmur	☐ High Cholesterol	
☐ Hepatitis	☐ Liver Disease	
☐ High Blood Pressure	☐ Lung Disease	
☐ Kidney Stones	☐ Malignant Melanoma	
☐ Skin Cancer	☐ Obesity	
☐ Skin Disease	☐ Premature Coronary Heart Disease	
☐ Stroke	☐ Skin Cancer	
☐ Thyroid Disease	☐ Thyroid Disease	
☐ Tuberculosis	☐ Other_____	
☐ Stomach Ulcers		
☐ Bleeding Disorder		
☐ Other_____		

Social History

☐ I am a non-smoker and I do not use nicotine products ☐ I am a former smoker and I stopped approx. _____ years ago

☐ I am a smoker and I use tobacco/ nicotine products (gum, patches, vapor, marijuana) Frequency: _____ per day

Do you drink? ☐ YES ☐ NO Frequency: _____ drinks per week

Pharmacy Information

Pharmacy Name: _____

Cross Streets: _____ and _____

Zip Code: _____ Phone Number: _____

Allergies/ Medications

1. Are you currently taking any medications or supplements? ☐ YES ☐ NO
2. If yes, list medication(s)/supplements: _____
   _____
3. Are you allergic to any medications? ☐ YES ☐ NO
4. If yes, list your medication(s): _____
   _____

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Past Surgical History

Surgery	Year	Complication (Yes or No)
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Physician List (If Applicable)

Specialty	Physician Name	Phone Number
1. Referring Doctor		
2. Primary Care Physician		
3. Cardiologist		
4. Hematology/Oncology		
5. Nephrologist		
6. Other		

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Acknowledgment of Receipt of Privacy Notice

Original to be maintained in the patient's permanent medical record

I acknowledge that I have received a copy of the office's **Notice of Privacy Policies.**

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship Date

☐ **Please check here if you would like a copy of our Notice of Privacy Policies**

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I attest the medical information provided is current and accurate to the best of my knowledge. I understand the signed copy of the privacy policy will be placed in my chart indicating that I have read, understood and agree to this policy. A copy of this may be obtained at any time upon your request.

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that payment for services, whether cosmetic or not, is solely the responsibility of the patient or their guarantor. I hereby authorize Dr. Brown to bill my insurance company or other third parties responsible for my medical charges. I also authorize Dr. Brown to release any medical information that may be requested by my insurance company to help with the process of my claims. I authorize and request that payment be made directly to Dr. Richard J. Brown for all medical and surgical services. I understand that I am responsible for any balance not covered by my insurance company.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship Date