BROWN
PLASTIC SURGERY

Patient Information Form

Today's Date: _____

First Name: _____ **M.I.:** _____ **Last Name:** _____

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: _____ **Occupation:** _____

Address: _____ **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: _____

Scottsdale: 11000 N. Scottsdale Rd. Ste 100 Scottsdale, AZ 85254
Sun City: 13640 N. 99th Ave. Ste 400 Sun City, AZ 85351
Phone: 480.947.2455 **Fax:** 480.947.2456 **Web:** www.richardjbrownmd.com

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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	
☐ Autoimmune Disorders	☐ Autoimmune Disorders	
☐ Asthma	Ex: Lupus, R.A.	
☐ 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	☐ Other_____	
☐ Bleeding Disorder		

Social History

Do you smoke or use nicotine products (gum, patches, vapor, marijuana)? Yes / No If yes, how often:_____
Are you a former smoker? Yes / No If yes, when did you stop: _____
Do you drink alcohol? Yes / No If yes, how many drinks per week: _____

Pharmacy Information

Pharmacy Name: _____
Cross Streets: _____ and _____
Zip Code: _____ Phone Number: _____

Allergies/ Medications

Are you currently taking any medications or supplements? Yes / No
If yes, list medication(s)/supplement(s):
_____

_____
Are you allergic to any medications? Yes / No
If yes, list 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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Nicotine Policy

In some cases, complications from long-term nicotine usage may put you at too great a risk to undergo plastic surgery. If you are a nicotine user or have been one in the past, it is critical you notify Dr. Richard J. Brown and get specific clearance before proceeding forward with surgery.

Nicotine use, including but not limited to traditional cigarettes, electronic cigarettes, chewing tobacco, nicotine gum, and nicotine patches, have a direct effect on the outcome of plastic surgery.

Nicotine use increases your risk of surgical complications, including, but not limited to:

- Oxygen Shortage
- Blood Clotting
- Infections
- Skin Necrosis (Loss of Tissue)

In particular the use of nicotine shrinks your blood vessels which in turn restricts the special blood cells needed to travel to the healing areas of your body post-surgery.

In addition, nicotine and other chemicals in cigarettes make your blood more likely to clot, thus clogging capillaries and blood vessels. Unintentional clotting and blood thickening diminish blood flow to and from the operated area.

Plastic surgery procedures often involve reshaping or moving segments of your skin and blood tissue from one area of your body to another. In so doing, a portion of your blood supply to that particular tissue is intentionally severed. Under normal health conditions, your remaining blood supply is more than sufficient for proper healing of your tissue and skin. With nicotine use, however, your body will experience insufficient blood flow preventing your tissue from getting enough oxygen to survive and properly heal. This can often lead to inadequate wound healing or necrosis (severe loss of skin). Thus, it is critical that an adequate blood supply be available at time of surgery and after surgery for proper healing.

In effect, plastic surgery relies on adequate blood supply for proper healing and nicotine use restricts blood supply, which may lead to complications beyond the control of your surgeon.

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Nicotine-Related Surgery Requirements

(Please Initial on each line)

_____ As a surgery requirement, I understand and agree to remain nicotine free for at least four weeks prior to and four weeks after my surgery.

_____ I understand that I may be tested for Nicotine at the time of my pre-operative appointment. I agree that if my test is positive, I will be required to reschedule my surgery and I will be charged a $500 rescheduling fee.

_____ I understand that exposure to second-hand smoke can also lead to a positive nicotine test.

_____ I understand that I will be tested for Nicotine on the day of my surgery. **I agree that if my test is positive, my surgery will be cancelled, and all surgeon's fees forfeited. No refunds. No exceptions.**

_____ I understand that if it is determined my nicotine usage has caused the need for additional anesthesia, surgery care, or facility time, I will be charged at a rate of $1500 per hour for the additional time needed.

Regardless of whether I am an active nicotine user at the time I was given a copy of this Nicotine Policy, I fully understand the negative consequences as it relates to nicotine use and plastic surgery. I take full responsibility for any past, present, or future nicotine use. I agree to hold harmless, Dr. Richard J. Brown and anyone associated with Brown Plastic Surgery with regard to complications that may occur as a result of nicotine use. I will not pursue any legal action related to any complications that should occur as a result of nicotine use.

(Please check only one below)

☐ I am NOT an active nicotine user and have NOT been in the past.

☐ I am NOT an active nicotine user, but I have been in the past.

☐ I am an active nicotine user.

_____ _____

Patient Name Patient Date of Birth

_____ _____

Patient Signature Date

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Acknowledgment of Receipt of Privacy Notice

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.

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**

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