

Patient Information Form

C

Today's Date: _____

PATIENT INFORMATION:

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

Address: _____

City: _____ State: _____ Zip: _____

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

Home Tel: _____ Work Tel: _____ Cell: _____

E-mail: _____

Preferred Contact Method (Check box): 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

May we contact you by e-mail? Yes / No

May we use your e-mail for medical related correspondence? Yes / No

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

Emergency Contact _____ Phone# _____

Relationship To You: Spouse Family Friend Other: _____

Reason For Consult/Today's Visit: _____

WORK INFORMATION:

Employer Name: _____ Occupation: _____

Employer Address: _____ Phone# _____

INSURANCE INFORMATION:

Primary Insurance Carrier: _____ Phone#: _____

Policy # _____ Group# _____

Secondary Insurance Carrier: _____ Phone#: _____

Policy # _____ Group# _____

PRIMARY CARE PHYSICIAN

Name: _____ Phone# _____

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

Website Google Instagram Tik Tok RealSelf Facebook

Other: _____ Internet Keywords Used: _____

Doctor/ Insurance Referral: _____ Patient Referral: _____

Patient Health History

Patient Name: _____ Height: _____ Weight: _____

HEALTH & FITNESS

Are you Interested in our Nutrition Program? Yes No Maybe

Have you ever worked with a Nutritionist? Yes / No

Do you currently Exercise? Yes / No

If Yes, how many times a week? _____

MEDICAL HISTORY

Past Medical History	Family History	Afflicted Family Member
<input type="checkbox"/> Denies Past Medical History	<input type="checkbox"/> No Relevant Family History	
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Unknown - Adopted	
<input type="checkbox"/> Autoimmune Disorders	<input type="checkbox"/> Autoimmune Disorders	
<input type="checkbox"/> Asthma	Ex: Lupus, R.A.	
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Breast Cancer	
<input type="checkbox"/> Cancer (Other)	<input type="checkbox"/> Colon Cancer	
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Lung Disease	
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Malignant Melanoma	
<input type="checkbox"/> Skin Cancer	<input type="checkbox"/> Obesity	
<input type="checkbox"/> Skin Disease	<input type="checkbox"/> Premature Coronary Heart Disease	
<input type="checkbox"/> Stroke	<input type="checkbox"/> Skin Cancer	
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Other _____	
<input type="checkbox"/> 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: _____

Medications

Are you currently taking any medications or supplements? Yes / No

If yes, list medication(s)/supplement(s): _____

Allergies

Are you allergic to any medications? Yes / No

If yes, list medication(s): _____

Past Surgical History

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

Additional Information Regarding Surgical History”

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		

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.

I have Read and Understand Nicotine Policy for Brown Plastic Surgery:

Patient Print Name

Patient Date of Birth

Patient Signature

Date

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 Print Name

Patient Date of Birth

Patient Signature

Date

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

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: _____