PLASTIC SURGERY OF TEXAS

PATIENT INFORMATION

DATE: ____________________________ PHONE: __________________________________
WHO REFERRED YOU TO US: ____
NAME: ____ D.O.B.: _____________________
LAST FIRST MI

ADDRESS: ____
CITY: _____________________ STATE: ______________ ZIP: _______________________
H. PHONE #: ________________ W.PHONE #: _____________ MOBILE: ____________
S.S #: _____________________________ EMAIL: _________________________________
MARITAL STATUS (CIRCLE ONE): SINGLE MARRIED DIVORCED WIDOW
EMPLOYER: _______________________ ADDRESS: ______________________________
NAME OF SPOUSE: ____
S.S #: ______________________________ D.O.B.: _________________________________
SPOUSE EMPLOYER:__________________ ADDRESS: ___________________________
PHONE #: ____________________________ SPOUSE OCCUP: ______________________

IN CASE OF EMERGENCY CONTACT: ____
PHONE #:_________________________ RELATIONSHIP: ___________________________
REASON FOR OFFICE VISIT: ____

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***PRIMARY INSURANCE: ____
INSURED'S NAME: __________________________ INSURED'S ID #: ________________
GROUP#: ____________________________ PHONE#: ______________________________
CLAIM ADDRESS: ____
CITY: ____________________ STATE: _______________ ZIP: _______________________
***SECONDARY INSURANCE:
INSURED'S NAME: __________________________ INSURED'S ID #: ________________
GROUP#: ____________________________ PHONE#: ______________________________
CLAIM ADDRESS: ____
CITY: ____________________ STATE: _______________ ZIP: _______________________

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I understand that if any of the insurance information I have provided is incorrect or if I fail to notify the office of any insurance changes, that I am responsible for all physician charges.

I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitle to Ben J. Tittle, MD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original.

INSURED'S SIGNATURE

X____ **DATE:** ________________________

MEDICAL HISTORY

DATE: _____ NAME: _____ AGE: _____ D.O.B.: _____
Referring doctor: _____
How did you find out about us? _____

CONFIDENTIAL INFORMATION: Information contained herein will not be released except when you have authorized us to do so. Please answer all to the best of your knowledge. The information provided by you will be used by the doctor in his decisions regarding your care.

Why are you coming to see us? _____
How long has the problem been present? _____
Has the problem been treated by a doctor? No Yes, explain: _____
_____

Do you have or have you ever had the following? CIRCLE Yes or No, give date of occurrence:

Stroke	No Yes _____	Cancer	No Yes _____
Diabetes	No Yes _____	Bleeding Tendency	No Yes _____
High Blood Pressure	No Yes _____	Stomach Ulcer	No Yes _____
Heart Disease	No Yes _____	Back Problems	No Yes _____
Heart Attack	No Yes _____	Hepatitis	No Yes _____
Lung Disease	No Yes _____	Leukemia	No Yes _____
Bronchitis	No Yes _____	Psychiatric	No Yes _____
Pneumonia	No Yes _____	Thyroid Disease	No Yes _____
Tuberculosis	No Yes _____	Kidney Disease	No Yes _____

Have you ever had a blood transfusion? No Yes ____ Have you ever taken steroids? No Yes___
Height: _____ Weight: _____

Please list all operations or surgeries that you have had: _____
Serious injuries or accidents: _____
When was your last physical exam by a physician? _____
Have you or anyone in your family ever had problems with anesthesia? No Yes, Explain_
_____
List all medications that you take on a regular basis: _____
List all medications that you take on an occasional basis: _____
List all allergies that you have: _____
Do you smoke? No Yes How much? _____
Do you regularly drink alcoholic beverages? No Yes How much? _____
Do you wear glasses? No Yes Contact Lenses? Do you have dentures? No Yes
Where do you live? _____ What is your occupation? _____
Are you married? _____ What are your hobbies? _____
Is your mother living? Yes No, If No, would you list her age and cause of death? _____
_____ Her state of health: _____
Family history of breast cancer? No Yes
Is your father living? Yes No, If No would you list his age and cause of death?_____
_____ His state of health: _____
Are your siblings healthy? Yes No, if No please explain: _____
Have you been sick or had any illness in the last month? No Yes, explain: _____

PLASTIC SURGERY
OF TEXAS

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed Plastic Surgery of Texas Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand and I am entitled to receive a copy of this document.

_____
Signature of Patient

_____
Print Name

_____
Date

_____
Signature of Personal Representative

_____
Print Name

_____
Date

_____
Description of Personal Representative's Authority

PLASTIC SURGERY

OF TEXAS

PATIENT PHOTOGRAPH CONSENT FORM

I undersigned hereby authorizes ______________________ M.D. to take photographs of me and to use them as an aid in my treatment. I understand these photographs will become part of my permanent record.

Signature: ___________________________________ Date: _____________________________

PST Rep: ___________________________________ Date: _____________________________

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In an effort to give the patient a better understanding of the results that can be achieved, we often use visual aids such as the photographs/slides that were taken of your particular case.

By signing the consent, you will allow your photographs/slides to be shared by others who have the same or similar procedure. Please understand that your photographs/slides never show faces unless, of course, the face is involved.

Signature: ___________________________________ Date: _____________________________

PST Rep: ___________________________________ Date: _____________________________