LELAND R. CHICK, M.D., F.A.C.S.

DIPLOMATE AMERICAN BOARD OF PLASTIC AND RECONSTRUCTIVE SURGERY

PATIENT INFORMATION **TODAY'S DATE** ____/____/____

Name _____
First MI Last

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Date of Birth ____/____/____ Social Security Number _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed

Employer _____ Work Phone _____

SPOUSE INFORMATION

Name _____
First MI Last

Date of Birth ____/____/____ Social Security Number _____

Employer _____ Work Phone _____

IF PATIENT IS A MINOR

Father's Name _____
First MI Last

Date of Birth ____/____/____ Social Security Number _____

Employer _____ Work Phone _____

Mother's Name _____
First MI Last

Date of Birth ____/____/____ Social Security Number _____

Employer _____ Work Phone _____

CONTACT INFORMATION

For Emergency List Relative (not in same household) _____

Relationship _____ Phone _____

Address _____
City State Zip

Please name one person we may leave information with, in case of urgency? _____
Name Phone #

Who may receive your health or financial information? _____
Name

MEDICAL HISTORY

Please fill out this brief medical history if this is your first visit in this office

What is the reason for your visit? _____

_____

Who referred you to our office? _____
(if physician please list address and office phone #)

Date Symptoms Noticed ____/_____/_____

Are you allergic to iodine? Yes ☐ No ☐ Are you allergic to shellfish? Yes ☐ No ☐

Are you allergic to latex? Yes ☐ No ☐

Do you have any allergies to medications? Yes ☐ No ☐ Please List: _____

_____

Please list current medicines you are taking and dosage, if possible: _____

_____

_____

_____

Have you taken aspirin or an anti-inflammatory medication lately? (do not include Tylenol) Yes ☐ No ☐

How frequently and how many do you take? _____

Please list approximate dates of your previous surgeries **which affect your current problem**: _____

_____

Other surgeries? _____

_____

Do you have diabetes? Yes ☐ No ☐ Heart disease? Yes ☐ No ☐

Lung disease? Yes ☐ No ☐ High blood pressure? Yes ☐ No ☐

Rheumatoid arthritis? Yes ☐ No ☐

Previous heart attack? Yes ☐ No ☐ When? ____/_____/_____

Have you had a stroke? Yes ☐ No ☐ When? ____/_____/_____

Have you had cancer? Yes ☐ No ☐ When? ____/_____/_____ What type? _____

Are you pregnant? Yes ☐ No ☐ How many pregnancies have you had? _____

Do you smoke? Yes ☐ No ☐ How many packs per day? _____ For how long? _____

How tall are you? _____ About what do you weigh? _____

INSURANCE INFORMATION

(We require a copy of your insurance card(s) for our files)

PRIMARY INSURANCE

Insurance Company _____ Phone # _____

Address _____
City State Zip

Group # _____ Policy # _____

Name of policy holder _____
First MI Last

Relationship to you ☐ Self ☐ Spouse ☐ Child ☐ Other(please specify)_____

SECONDARY INSURANCE

Insurance Company _____ Phone # _____

Address _____
City State Zip

Group # _____ Policy # _____

Name of policy holder _____
First MI Last

Relationship to you ☐ Self ☐ Spouse ☐ Child ☐ Other(please specify)_____

INJURY RELATED

Is your condition related to any of the following:

☐ Work Injury ☐ Motor Vehicle Injury ☐ Previous Surgery

Date of injury or surgery ____/____/____

Description of injury or surgery _____

Adjuster's Name _____ Claim # _____

If legal proceedings are involved regarding any of the above, please list your attorney's name, address and telephone number:

Name _____ Phone # _____

Address _____
City State Zip

FINANCIAL AGREEMENT

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to the physician. I am aware that whether I am the patient, or the agent of the patient, I obligate myself to pay the physician in accordance with the regular rates and terms not covered by my insurance. All delinquent accounts bear interest at the legal rate. If legal action is required to collect fees for this service I agree to pay reasonable collection/ legal fees.

Signature of Patient or Guardian_____ **Date:**____/____/____