

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name

_____ Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? No Yes E-mail _____

Contact Drivers License #
Restrictions: _____ (include State) _____

Age _____ Birthdate ____/____/____ SS# ____-____-____ Sex Female Male

Marital Status Single Married to: _____ Other: _____

Patient's Employer

_____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes No

Address _____
Street & Suite # City State Zip

Emergency Contact

(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

Primary Health Insurance Company

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____

Insured: Name _____ DOB _____ Employer _____

For the services rendered and those about to be rendered, I hereby assign to Dr. David N. Csikai any and all medical and/or surgical benefits otherwise payable to me under the above described policy not to exceed the charges made for such treatment. I further authorize the above insurance company to pay said benefits directly to Dr. David N. Csikai and further direct that they make no payments directly to me. I understand that I am directly and primarily responsible to the physician for his ordinary and customary fee for the services rendered to me. I realize that if my insurance company fails to pay or if there is no payment made within 60 days it is my responsibility to pay my doctor's bill directly. I further understand and agree if I fail to make timely payments on my account that I will be responsible for any and all reasonable costs of collection including filing fees as well as a reasonable attorney's fee. I hereby authorize Dr. David N. Csikai to release to my insurance company any information acquired, including the diagnosis and records in the course of my examination or treatment.

Signature _____ **Date** _____

It is our policy that office visits be paid for at the time services are rendered. You will be paying by: check _____ cash _____ cc _____
Would you like to receive mail-outs from our office only regarding new skin care products/procedures or promotions? Yes ___No___

PRESENT PROBLEM

Specific problem(s) for which you are seeking plastic surgery: _____

How long has this been a problem? _____

Have you consulted any other doctors, including plastic surgeons, about this? No Yes If yes, please list their names

PAST MEDICAL HISTORY

GENERAL HEALTH: Good Fair Poor If not "Good", please explain _____

Height _____ Weight _____ Most you have ever weighed _____

SERIOUS ILLNESSES OR INJURIES (please list) _____

PREVIOUS SURGERY (Please list) _____

Have you had significant complications or after effects from any of these operations ? No Yes

If "yes", please explain _____

Have you had any complications from anesthesia ? No Yes If "Yes" please explain _____

FAMILY HISTORY

Has any relative had:

Cancer.....No Yes Diabetes.....No Yes Heart Disease.....No Yes
High Blood Pressure.....No Yes Mental Disease.....No Yes Sickle Cell.....No Yes

MEDICATIONS, DRUGS

What is your daily consumption of the following: Tobacco____ Alcohol____, and Drug Use _____

Please list all medications you are now taking (including birth control pill, diuretics (water pills), blood pressure or heart medications, tranquilizers, hormones, blood thinners, aspirin, bufferin, etc.)

Patient Referred by _____

Family Doctor or Internist _____ Address _____

Has this office ever seen or treated any member of your family? No Yes

PERTINENT PREOPERATIVE INFORMATION

Are you allergic to any medications, tape, etc. ? No Yes
If yes, which ones and how did they affect you? No Yes
Have you required unusually large amounts of local anesthetic for medical or dental procedures? No Yes
Do you have high blood pressure? No Yes
Have you ever had Scarlet or Rheumatic Fever No Yes
Do you bleed unusually easy? No Yes
Are you a slow or poor healer ? No Yes
Do you form large scars or keloids? No Yes
Do you have any skin disease, hives, eczema or rash? No Yes
Do you have frequent infections or boils? No Yes
Have you ever taken steroid medications, cortisone, or ACTH? No Yes
Do you have shortness of breath while walking? No Yes
Do you have, or have you had any significant emotional problems? No Yes
Have you ever had psychiatric care? No Yes
Have you ever been advised to see a psychiatrist? No Yes
Have you ever had a blood transfusion? No Yes
Have you ever had hepatitis? No Yes

Have you ever had any of the following illnesses? (Circle if Yes)
Brain Nose Chest Stomach Bladder Arms Eyes Throat Lungs Intestines
Reproductive Systems Legs Ears Neck Heart Kidney Nervous System Breasts

If circled, please explain _____

Signature _____