Please Help Us!

We would like to know how you heard about

LANDON PLASTIC SURGERY.

Your Name: ________________________________Date:___________

PLEASE SELECT ALL THAT APPLY:

☐ **Friend/Family** *** Please write name so that we can thank your referral**

Name____

☐ **Magazine:**

Neighborhood News

☐ **Radio:**

☐ **Internet: Website Name:** _________________________________

☐ **Billboard- Location:** _____________________________________

☐ **Drs. Office- Drs. Name:** __________________________________

☐ **Event- Name:** ____

☐ **Yellow Pages:**

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PATIENT INFORMATION FORM

Name ________________________________ Date _____________
(Last, First, MI)

Reason for Visit ____

Date of Birth _____________ Age ________

Marital Status: Single Married Divorce Widowed

Address ____________________________________ City ___________ State _____ Zip ______

Home Phone _________________________ Cell Phone __________________________

Work Phone _________________________

Spouse's Name ____

Emergency Contact ________________________________ Relationship _______________

Emergency contact # ______________________ Alternate # ____________________

Are you interested in receiving E-mail updates, specials, open houses, & newsletters about Landon Plastic Surgery and The Spa Boutique? If so, please provide us with your E-mail address____

If patient is a Minor (under 18 years of age)

Parent's Name ______________________________________
(Last, First, MI)

Phone __________________________ Alternate phone # ________________________

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PATIENT INFORMATION

Date ______ **Patient Name** ____ **Female/Male (circle)**

Last First Middle

Age _____ **Date of Birth** ___________ **Height** ______ **Weight** _____ **Occupation** _______________

Reason for your visit ____

PAST MEDICAL CONDITIONS (mark all that apply)

___ No past medical history
___ AIDS
___ Alcoholism
___ Anemia
___ Anesthesia Problems
___ Autoimmune Disorder
___ Arthritis
___ Asthma
___ Bleeding Disorder
___ Breast Cancer
___ Cancer
___ Chest Pain/tightness

___ Depression/anxiety
___ Diabetes
if yes: Insulin Y / N
___ Heart Disease
___ Heart Attack date ______
___ Hepatitis
___ Heart murmur
___ Healing Problems
___ High Blood Pressure
___ High Cholesterol
___ HIV Positive
___ Inflammatory Bowel Disease
___ Kidney Disease

___ Liver Disease
___ Lung Disease
___ Malignancy
___ Pacemaker
___ Post Radiation Therapy
___ Psychiatric Care
___ Skin Cancer/ Melanoma
___ Stroke
___ Substance Abuse
___ Thyroid Problem
___ Tuberculosis
___ Transfusion _______

FEMALES ONLY:

___ Fibrocystic Breasts
___ BRCA Gene positive
___ Going through Menopause
___ Ovarian Cancer
___ Last Mammogram Date: ____
Normal Y/N
___ # Pregnancies _____
___ # Live births _______
___ Ages of Children _______
___ Plan becoming Pregnant? Y/N

HEALTH HISTORY

HAVE YOU HAD IN THE LAST MONTH OR DO YOU PRESENTLY HAVE:

___ CHF (Congestive Heart Failure)
___ Serious infection or sepsis
___ Central Venous Access (IV Access)
___ Elective Hip or knee Replacement
___ Hip, pelvis, or leg fracture
___ Surgery (explain below)
___ History of unexplained stillborn infant, 3 or more spontaneous abortions, premature birth with toxemia or growth restricted infant

___ Serious Trauma
___ Spinal Cord Injury/paralysis
___ Non - removable plaster cast or mold
___ Pregnancy or postpartum
___ Visible Varicose Veins
___ Have swollen legs
___ Confined to bed for 72 hrs or more

SURGICAL HISTORY: list any surgeries/hospitalizations with year

SURGERY/HOSPITALIZATION (include cosmetic procedures) **YEAR**

____
____
____
____
____
____
____

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CURRENT MEDICATIONS (include Vitamins & Supplements)

ARE YOU TAKING?

ASPIRIN? Y / N ORAL CONTRACEPTIVES? Y / N CHEMOTHERAPY? Y / N

INSULIN? Y / N HORMONE REPLACEMENT THERAPY Y / N

Drug Name	Dose	Frequency

ALLERGIES:

Please list all medication / Substance Allergies

LATEX Y / N

____

____

____

____

____

____

SOCIAL HISTORY

Do you smoke? Yes ____ No _____ Yes/How much? _________ No/Date quit: _______

Do you drink alcohol? Yes ____ No _____ Drinks per week: ________

Substance Abuse: Yes ____ No _____ Drug: _________________ How often? __________

FAMILY HISTORY

Do you have a family history of trouble with anesthesia Yes_____ No ______

Do you have a family history of easy bleeding or clotting Yes _____ No ______

Family history of positive blood test for increased risk of clotting (Factor V Leiden) Yes _____ No ______

PHARMACY INFORMATION

Please provide us with your Pharmacy Name: ___________________________ Pharmacy # _______________________

I CERTIFY THAT I HAVE DISCLOSED MY MEDICAL HISTORY TO THE BEST OF MY KNOWLEDGE.

____ **Patient Signature**

__________________________________ **Date**

____ **Print Name**

Landon Plastic Surgery

RIGHT TO SHARE INFORMATION WITH FAMILY AND FRIENDS

Landon Plastic Surgery & the Spa Boutique reserves the right to communicate protected health information (PHI) with family or friends when it is deemed in the best interest of the patient as described in the Notice of privacy. In order to have your PHI shared in other circumstances with the members of your family or friends, please list those individuals that we are authorized to release information.

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ____________________

Signature of Patient **Date**

Landon Plastic Surgery DOES NOT contract with any private medical insurance companies, including but not limited to Medicare and/or Medicaid.

Your signature below acknowledges your understanding that services rendered are strictly fee for service. Please be advised that we are unable to provide ANY information to insurance companies.

______________________________ ______________________________ ______________

Patient Signature **Print Name** **Date**

Please be advised that I authorize Landon Plastic Surgery or whomever they designate to represent them to transmit any medical data over the computer lines or telephone lines by means of cell phone (texting) or fax lines. I understand that it is possible that such transmission of this information could inadvertently wind up in the wrong hands. However, the timely transmission of this information is important enough for me to accept the risk.

______________________________ ______________________________ ______________

Patient Signature **Print Name** **Date**

Landon Plastic Surgery

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give consent to Landon Plastic Surgery and all health care providers furnishing care within the practice to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Please be advised that our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by contacting our Privacy Officer at 727-376-3999.

You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the above address and will be effective when said notification is received. Your revocation will not be effective to the extent that we or others have acted in reliance upon the consent.
I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

______________________________	___________________________	_______________
Patient Signature	**Print Name**	**Date**

If you are signing as patient's representative, print your name: _______________________
Describe your relationship to the patient: ____