forma
PLASTIC SURGERY

5010 East Shea Blvd, Suite 175 ◆ Scottsdale, AZ 85254
Phone: (480) 657-2000 ◆ Fax: (480) 657-2011

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ ☐ MALE ☐ FEMALE

Street Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Date of Birth: _____ Email Address: _____

Marital Status: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

Employer: _____ Occupation: _____

How did you hear about us? _____

Would you like to be added to our mailing list for specials and promotions? ☐ ***Yes*** ☐ ***No***

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Contact # _____

REASON FOR CONSULT

☐ Breast Enlargement ☐ Breast Lift ☐ Breast Reduction ☐ Breast Reconstruction ☐ Implant Exchange
☐ Tummy Tuck ☐ Liposuction ☐ Body Lift ☐ Body Contouring after Massive Weight Loss
☐ Facelift ☐ Eyelid Lift ☐ Neck Lift ☐ Rhinoplasty ☐ Otoplasty
☐ Skincare ☐ Radiesse ☐ Restylane/Perlane ☐ Botox/Dysport ☐ Chemical Peel
☐ Scar Revision ☐ Other: _____

SKIN CONCERNS/ PRODUCTS OF INTEREST

☐ Dry Skin ☐ Thin Lips ☐ Blotchy Skin
☐ Oily Skin ☐ Inadequate Eye Lashes ☐ Facial Redness ☐ SkinMedica
☐ Combination Skin ☐ Facial Fine Lines ☐ Aging ☐ Skinceuticals
☐ Pigmentation ☐ Facial Fullness ☐ Drooping Eyelids ☐ Latisse
☐ Uneven Skin Tone ☐ Do you use sunscreen?: _____

HEALTH & MEDICAL INFORMATION

Primary Care Physician: _____ **Phone #:** _____

Age: _____ **Height:** _____ **Weight:** _____ **BMI:** _____ (for office use only)

Have you ever smoked? ☐ Yes ☐ No * If yes, _____ packs/day for _____ year(s). **Do you still smoke?** ☐ Yes ☐ No

How much alcohol do you drink? _____ Drinks per: ☐ day ☐ week ☐ month

How much caffeine do you drink? _____ Drinks per: ☐ day ☐ week ☐ month

List the dates of your most recent:

Physical: _____ Normal? ☐ Yes ☐ No EKG: _____ Normal? ☐ Yes ☐ No
Chest X-Ray: _____ Normal? ☐ Yes ☐ No Blood Work: _____ Normal? ☐ Yes ☐ No

WOMEN ONLY:

How many pregnancies have you had? _____ How many children have you born? _____ How many C-Sections? _____

Is there a chance that you are currently pregnant? ☐ Yes ☐ No Date of most recent breast exam: _____

Are you having regular menstrual periods? ☐ Yes ☐ No Date of most recent mammogram: _____

Do you experience heavy bleeding with your periods? ☐Yes ☐ No

ADDITIONAL HEALTH & MEDICAL INFORMATION

MEDICATIONS: Please list all the medications you are currently taking, prescription and non-prescription, supplements, vitamins, diet pills and those medications you make take on an as needed basis. Please also include the dose of the medication.	
MEDICATIONS & DOSAGE	
ALLERGIES: Please list all allergies to medications, tape, latex, iodine, etc. and the reaction that you have when exposed.	
	☐ **I HAVE NO KNOWN DRUG ALLERGIES**

SURGICAL HISTORY:

Please list any surgeries and/or serious accidents or injuries. Please include the date of the surgery, accident or injury.

Have you and/or any of your family members had any history of anesthesia complications? ☐ Yes ☐ No

If yes, please describe: _____

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS: Please check all that apply to YOU.

NEUROLOGICAL	**BLOOD**	**PULMONARY**	**CARDIOVASCULAR**	**SKIN/IMMUNE**
☐ Migraines	☐ Anemia	☐ Asthma	☐ Heart Disease	☐ Arthritis/Joint Pain
☐ Stroke	☐ Bleeding Disorder	☐ Tuberculosis	☐ Chest Pain	☐ Back/Neck Pain
☐ Seizures	☐ Blood Clots/DVT	☐ Emphysema	☐ High Blood Pressure	☐ Skin Disorder(s)
☐ Head Injury	☐ AIDS/HIV	☐ COPD	☐ Heart Attack	☐ Autoimmune Disorders
☐ Depression	☐ Nose Bleeds	☐ Pulmonary Embolism	☐ Heart Murmur	☐ Lupus/Scleroderma
	☐ Prior Transfusion		☐Swollen extremities	☐ Pigmentation Issues
			☐ Palpitations	
GENERAL	**HEAD/NECK**	**ENDOCRINE**	**GASTROINTESTINAL**	**ALLERGY**
☐ Fever	☐ Change in vision	☐ Heat/Cold Intolerance	☐ Constipation	☐ Tape Allergy
☐ Weight Loss/Gain	☐ Nasal blockage	☐ Diabetes	☐ Reflux disease	☐ Environmental
☐ Night Sweats	☐ Sore throat	☐ Thyroid Problems	☐ Diarrhea	☐ Iodine Allergy
☐ Loss of Appetite	☐ Sinusitis		☐ Hepatitis/Jaundice	☐ Latex Allergy
	☐ Wear contacts/glasses		☐ Frequent Urinary Infections	
			☐ Hernia	
☐ **CANCER: (TYPE)**		☐ **OTHER:**		☐ **NONE OF THE ABOVE**

FAMILY HISTORY: Please check those that apply to your family members:

☐ Blood clots/DVT	☐ Bleeding Disorder	☐ Asthma	☐ Breast Cancer	☐ Stroke
☐ High Blood Pressure	☐ Heart Disease	☐ Diabetes	☐ Other	☐ **NONE OF THE ABOVE**

The above information is accurate and complete to the best of my knowledge.

_____ _____

Patient Signature **Date**

FOR OUR INSURANCE PATIENTS: Payment Authorization Notice and Release of Information

I understand that visit charges are payable on the day service is rendered. I authorize ER Plastics PLLC, Niagara Plastics PLLC, or Quad M Med, PLLC to bill my insurance company for medically necessary services. Regardless of insurance coverage, I understand that I am financially responsible for charges not covered by this authorization, including deductibles and co-pays. Furthermore, I hereby authorize ER Plastics PLLC, Niagara Plastics PLLC, or Quad M Med, PLLC, to release such information in connection with this treatment to my insurance company and/or hospital benefits program, which is necessary for payment by same. I understand this contract is between ER Plastics PLLC, Niagara Plastics PLLC, or Quad M Med, PLLC.

_____ _____

Patient Signature **Date**