PRECISION PLASTIC SURGERY, P.C.

PATIENT ENROLLMENT FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid		
Street address:	City, State	Zip	Birth date: / /	Age:	Sex: ❑ M ❑ F
Social Security no.:	Home phone no.: ( )	Cell phone no.: ( )			
Occupation:	Employer:	Employment Status: ❑Full-time ❑Retired ❑ Part-time ❑ Unemployed			
Injury Date:	Is this a work related injury? ❑ YES ❑NO	Employer phone no.:			

Did you see Dr. Lionelli in the Emergency Room? ❑ YES ❑NO List Hospital:

Where you referred from the Emergency Room? ❑ YES ❑NO List Hospital:

How did you hear about us?

❑ Family: ______________________ ❑ Friend: ______________________ ❑ Physician: __________________________ ❑ Insurance Directory ❑ Other

Referring Physician:	Phone No.:
Primary Care Physician:	**Phone No.:**

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address **(if different):**	Home phone no.: ( )
Subscriber's name:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

If you are covered by more than one insurance , please list the insurance company name in sequence.

Primary Insurance Name: ______________________________

Secondary Insurance Name:____________________________

IN CASE OF EMERGENCY

Name of Emergency Contact:	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Precision Plastic Surgery, P.C. or insurance company to release any information required to process my claims.

Patient/Guardian signature ______________________ *Date* ______________

Name: ____

Describe primary reason for todays visit:

____

Please check the box of the symptoms you are currently experiencing:

Symptom	**Yes**	**Symptom**	**Yes**	**Symptom**	**Yes**
Back Pain		Fever or Chills		Ringing in the ears	
Bleeding problems		Headaches/Migraines		Skin problems	
Chest Pain		Heartburn/Indigestion		Swelling	
Difficulty Breathing		Joint Discomfort/Pain		Urinary Problems	
Dizziness		Muscle Pain		Weight Gain	
Eye/Vision Problems		Nose Bleeds		Weight Loss	
Fatigue		Numbness/Tingling		Nausea/Vomiting	
Other:					

PAST MEDICAL HISTORY

Check YES below if you currently being treated for OR have been treated in the past.

Problem	**Yes**	**Problem**	**Yes**	**Problem**	**Yes**
Anxiety		GERD		Prostate	
Arthritis (Rheumatoid)		Heart Attack		Psoriasis	
Asthma		Heart Disease		Psychiatric Care	
Cancer(describe)		Hepatitis (A B C)		Pulmonary Embolism	
High Cholesterol		High Blood Pressure		Seizure Disorder/Epilepsy	
Diabetes		HIV/AIDS		Stomach Ulcers	
Emphysema/COPD		Kidney Disease		Stroke/ TIA	
Fibromyalgia		Mitral Valve Prolapse		Thyroid Disease	
Other:					

Family History

	Mother	Father	Sister	Brother	Grandparent	Other
Diabetes						
Heart Disease						
Breast Cancer						
Melanoma						
Other:						

Last Name First Name Middle Initial

PREFERRED PHARMACY INFORMATION

Pharmacy Name Phone Number Address

MEDICATIONS & VITAMINS

Please list all of your medications and the dosage amount:

Medications	Dosage, how many times a day
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Please list all vitamins, supplements and other over the counter products.

Vitamins/OTC	Dosage
1.	
2.	
3.	
4.	
5.	

Please list medication **ALLERGIES** or medications you cannot take.

Allergy	Yes	Reaction	Allergy	Yes	Reaction
Adhesive/Tape			Novocain		
Aspirin			Penicillin		
Codeine			Shell Fish		
Iodine			Sulfa Drugs		
Latex			X-ray Dye		
Other:					

Check here if **NO** allergies. ☐

Past Surgical History

Please place a check mark in the box if you have ever had any of the following surgeries.

Surgery	Year	Surgery	Year
○ Angioplasty		○ Gallbladder Removed	
○ Angioplasty w/ stent		○ Colectomy	
○ Appendectomy		○ Gastric Bypass	
○ Knee Surgery		○ Hernia Repair	
○ Back Surgery		○ Hip Replacement	
○ Bypass Surgery		○ Knee Replacement	
○ Carpal Tunnel		○ Hysterectomy	
○ Cataract		○ Pacemaker	
○ Thyroidectomy		○ Tonsillectomy	
○ Vasectomy		○ Oral Surgery	
Please another surgeries:			

Social History

Do you use tobacco?	¨ **NO**	¨ **YES**	¨ **Former**		
If cigarettes, # of packs per day?		**Year started?**		**Year Quit?**	
Other tobacco (chewing or cigars) per day?		**Year started?**		**Year Quit?**	
Do you use illegal drugs?	¨ **NO**	¨ **Yes**	¨ **Former**		

Do you regularly drink caffeinated beverages?	¨ **NO**	¨ **YES**	**How much/day?**	
Do you drink alcohol?	¨ **Currently**	¨ **Never**	¨ **Former**	**Date Quit?**
Daily amount?		**How Often?**		

Demographic

What is your primary language? English _____ Spanish_____ Bosnian_____ Other_____

What is your race? Black/African American _____ White_____ Asian_____

What is your Ethnicity? Hispanic or Latino _____ Not Hispanic or Latino_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered/provided a copy of the Notice Practices and that I have read (or had the opportunity to read, if I chose) and understood the notice.

Patient Name (please print) Date

Signature Parent or Authorized Representative (if applicable)

Consent for Treatment

I certify that all of the above information is true and correct to the best of my knowledge. I give permission to the doctor and his assistants to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition(s).

Signature of patient or Authorized Representative Date