PATIENT INFORMATION

PLEASE PRINT DATE______________________

NAME____

ADDRESS____

CITY_________________________STATE______ZIP_______E-MAIL__________________________
OUT OF STATE ADDRESS____

HOME #_________________CELL #______________________WORK #________________________

EMPLOYED BY_______________________________POSITION_______________________________

MARITAL STATUS____________SEX_______DATE OF BIRTH__________________AGE________

SOCIAL SECURITY #____________________DRIVER'S LICENSE # We will photocopy your license

SPOUSE OR PARENT/GUARDIAN INFORMATION:
NAME____RELATION TO PATIENT________________
EMPLOYED BY_____________________________________WORK PHONE____________________

RESPONSIBILITY FOR PAYMENT:
NAME____RELATION TO PATIENT________________
ADDRESS____
HOME PHONE___________________________________WORK PHONE__________________________

GENERAL INFORMATION:
REFERRED BY___________________________*May we send a thank you to this person ? Yes___No___*

REASON FOR SEEING DOCTOR/**LIST PROCEDURE**____

IF ACCIDENT-DATE OF INJURY_______________DO YOU HAVE AN ATTORNEY FOR THIS PROBLEM?_____________

ARE YOU **ALLERGIC** TO ANY MEDICATION?_______PLEASE LIST__________________________
____

AUTHORIZATION FOR DISCLOSURE OF INFORMATION: I authorize Dr. Cristina F. Keusch to disclose complete information concerning her medical findings and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who in Dr. Keusch's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.
RELEASE OF INFORMATION/MEDICAL RECORDS: I hereby authorize Dr. Cristina F. Keusch to release any information acquired in the course of my examination or treatment to my attorneys, physicians and/or insurance companies. I hereby authorize photocopies of this form to be as valid as the original. This statement will remain in effect until revoked by me in writing.

DATE______________________**SIGNATURE**____

PHOTOGRAPHS: Pre and post-operative photographs are essential in plastic surgery, both for planning and for the analysis of post-operative results. It is the policy of this office that patients scheduled for surgery will have photographs taken before and after surgery. These photographs are intended solely for use in this office. They cannot be shown to prospective patients nor can they be used in any talks or demonstrations without the expressed permission from you, the patient. I have read the above and fully understand the implications. I hereby give my consent to allow Dr. Keusch to take pre-operative, intra-operative and post-operative photographs of me. **DATE**____________**SIGNATURE**______________________________________

PRIVACY ACT: I authorize Dr. Keusch and her staff to call me, leave messages and confirm appointments, etc., in connection with my care. Please check the following:

HOME________**CELL**________**WORK**_______ **DATE**_____________**SIGNATURE**______________________________

MEDICAL INFORMATION

LIST ALL PREVIOUS SURGERY/HOSPITALIZATIONS, INCLUDING REASON:

Surgery-Hospitalization/Reason	Hospital	Type of Anesthesia	Year
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______

ANESTHESIA COMPLICATIONS______

LIST ALL MEDICATIONS YOU ARE TAKING, INCLUDING:EYE DROPS,OINTMENTS, VITAMINS/ HERBS

Medication	Dosage Amount	How Often Each Day
______	______	______
______	______	______
______	______	______

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD:

( ) Emphysema, Asthma, Bronchitis, Tuberculosis
( ) Diabetes
( ) Thyroid Disorders Hyper or Hypo, etc.
( ) Pancreas Disorders
( ) Stomach Problems, Ulcer
( ) Liver Disease, Hepatitis, Jaundice
( ) Kidney Disorders, Bladder Infections, Urinary Symptoms
( ) Pre-Menstrual Syndrome
( ) Pre /Peri /Post Menopausal CIRCLE ONE

( ) Cancer
( ) High or Low Blood Pressure
( ) Heart Murmur
( ) Irregular/Fast Heartbeat
( ) Angina
( ) Seizure Disorder/Epilepsy
( ) Rheumatic Fever
( ) Circulatory Problems
( ) Blood Transfusion Reactions
( ) Excessive Bleeding
( ) Stroke

( ) Headaches
( ) Fainting Spells/Syncope
( ) Glaucoma
( ) Cataracts
( ) Dry Eye Syndrome
( ) Radiation Treatment
( ) Arthritis
( ) Use of Acutane
( ) Psychiatric Treatment
( ) Prostrate Problems

YES	NO	
( )	( )	Do you have any skin problems? If yes, describe______
( )	( )	Prone to cold sores:______
( )	( )	Do you smoke? If yes, how much per day?______
( )	( )	Are you a former smoker? If yes, when did you stop smoking?______
( )	( )	Do you drink alcoholic beverages? If yes, how much per day?______
( )	( )	Do you have vision problems? If yes, explain:______
( )	( )	Do you wear eyeglasses?______ Do you wear contact lenses?______
( )	( )	Do you wear removable dental appliances/dentures?______
( )	( )	Do you have dental caps or crowns?______
( )	( )	Do you now, or have you ever used "street drugs"?______
( )	( )	Are you pregnant?______
( )	( )	Do you have any allergies to foods, medications or environment? If yes, explain:______
( )	( )	DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK THE DOCTOR SHOULD KNOW ABOUT? IF YES, EXPLAIN:______

PRIVATE/PERSONAL PHYSICIAN:______ Date of Last Exam______

ADDRESS______TELEPHONE#______

Last known blood pressure______Date of last: EKG______Chest X-Ray______Mammogram______

HEIGHT______CURRENT WEIGHT______

I HAVE READ (or have had read to me) THE ABOVE MEDICAL INFORMATION LISTED AND I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Signed______**Date**______

(Parent/Guardian, if patient is a minor)

Cristina F. Keusch M.D., P.A., F.A.C.S.
DIPLOMATE AMERICAN BOARD OF PLASTIC SURGERY
DIPLOMATE AMERICAN BOARD OF SURGERY
FELLOW AMERICAN COLLEGE OF SURGEONS

PATIENT CONSENT FOR USE OF CREDIT CARDS, DEBIT CARDS AND FINANCING

DISCLOSURE OF PROTECTED HEALTH INFORMATION

It may be necessary to release your protected health information to financial parties, credit card entities, banks and financing companies, when requested to facilitate your payment.

Services that are performed that are paid with a credit card, debit card or financing third party are not eligible for payment challenges after services are provided. Non-refundable deposits are also not eligible for payment challenges. By signing this form, I am irrevocably consenting to allow Cristina F. Keusch, M.D., P.A. to use and disclose my protected health information to any Credit Card Entity, Bank or Financing Company when they request such information to process an account and assist payment.

I will not challenge such credit, debit or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise.

I agree that this non credit card challenge agreement is irrevocable.

Signature of Patient or Legal Guardian____

Print Patient's name__________________________________Date________________

Member
AMERICAN SOCIETY OF PLASTIC SURGEONS

MEMBER
THE AMERICAN SOCIETY FOR AESTHETIC PLASTIC SURGERY
The Mark of Distinction In Cosmetic Plastic Surgery®

950 Glades Road Suite 3A • Boca Raton, FL 33431
561-368-9455 • Fax 561-394-8210 • www.DrKeusch.com