WALTZMAN
— PLASTIC & RECONSTRUCTIVE SURGERY —

Patient Information Form

Name_____

Date of Birth_____Gender_____

Address _____

City_____State_____Zip_____

SS# _____

Home Phone (_____)_____

Cell Phone (_____)_____

E-mail Address _____

Occupation _____

Employer_____

Ethnicity

□ Hispanic or Latino □ Not Hispanic or Latino □ Decline

Race

□ American Indian □ Asian □ Black or African American

□ Pacific Islander □ White □ Other Race □ Decline

If patient is a minor, who has legal custody and can make medical decisions for the patient?

□ Mother □ Father □ Other

Name_____

Who should we contact in case of an emergency?

Name_____

Relationship_____

Phone (_____)_____

Who referred you to our office?

□ Doctor □ Patient □ Friend □ Internet □ Other

Name_____

Primary Care Physician (complete in full)

Physician Name_____
first last

City_____

Phone (_____)_____

Authorization for Payment/Release of Medical Records

I authorize release of medical records and payment of benefits to the physician and allow a photocopy of my signature to be used to file insurance. I understand that my insurance may not cover all fees and services provided and I will be responsible for the unpaid balance.

Signed:_____Date_____

Photography Consent

I authorize the physician or his/her assistant to take digital photographs. These photographs are the doctor's property. The photographs will be a permanent part of the record and they will be used for surgical, office, and insurance purposes.

Signed:_____Date_____

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

□ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____

Signed:_____Date_____

Consent for use of credit cards, debit cards, and financing – disclosure of protected health information

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payments. Services that are performed and paid with a credit card, debit card, or financing third party are not eligible for payment challenges.
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.

Signed:_____Date_____

Josh Waltzman, M.D., M.B.A.
3828 Schaufele Ave., Suite 360•Long Beach, CA 90808
Main (562) 448-6100•Fax (562) 448-6101

Patient Name:_____

Age_____Height_____Weight_____

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Past Medical History

Please circle any medical conditions that you currently have:

Anemia/Thalassemia	COPD	Hypertension	Radiation Treatment
Anxiety	Coronary Artery Disease	HIV/AIDS	Renal Disorder
Arthritis	Deep Venous Thrombosis	Hypercholesterolemia	Seizures
Asthma	Depression	Hyperthyroidism	Severe Reaction to Anesthesia
Atrial Fibrillation(Irregular Heartbeat)	Diabetes	Hypothyroidism	Stroke
Auto-Immune Disease	GERD	Malignant Hypertension	Vision Loss
Bipolar Disorder	Head Trauma	Mental Health Hospitalization	Other_____
Blood Clotting Disorder	Hearing Loss	Pneumothorax	
Cancer in _____	Hepatitis	Pulmonary Embolism	

Past Surgeries

Please circle any surgeries you have had:

Abdominal Hernia Repair (Right,Left,umbilical)	Cesarean Section	Kidney Stone Removal	Skin: Basal Cell Carcinoma
Inguinal Hernia Repair (right,left)	Colon Resection Reason _____	Kidney Transplant	Skin: Squamous Cell Carcinoma
Appendix Removed	Gallbladder Removed	Lung Resection	Skin: Melanoma
Bladder Removed	Heart: Coronary Bypass Surgery	Ovaries Removed Reason_____	Spleen Removed
Mastectomy (right, left, bilateral)	Heart: Valve Replacement	Prostate Removed	Stomach Removed
Lumpectomy (right, left, bilateral)	Joint Replacement of _____	Small Bowel Resection	Testicles Removed (right, left, bilateral)
Breast Biopsy (right, left. bilateral)	Kidney Removed (right, left)	Spine Surgery	Uterus Removed Reason_____ Other_____

Gynecologic/Obstetric History

Last Menstrual Period_____

Last Mammogram_____

Number of Pregnancies_____

Number of Births_____

Skin Disease History

Please circle any skin conditions you have had:

Acne	Basal Cell Skin Cancer	Precancerous Moles	Melanoma
Eczema	Squamous Cell Skin Cancer	Psoriasis	Other_____

Do you wear sunscreen?	Yes	No	What SPF?_____
Do you tan in a tanning salon?	Yes	No	
Do you have a family history of Melanoma?	Yes	No	Which relative(s)?_____ _____

Plastic Surgery History

Please circle any plastic surgery you have had:

Abdominoplasty (Tummy Tuck)	Chemical Peel	Brow Lift	Scar Revision
Liposuction of_____	Cleft Lip/Palate	Facelift	Skin Graft
Body Contouring	Lower Blepharoplasty	Facial Fracture Repair	Other_____
Breast Augmentation	Upper Blepharoplasty	Rhinoplasty	
Breast Lift	Ear Surgery	Septoplasty	

Breast Cancer

Do you have a family history of breast cancer?

Yes No If yes, which relative(s):_____

Anesthesia Sensitivity and Malignant Hyperthermia

Do you have a family history of severe reactions to anesthesia or malignant hyperthermia?

Yes No If yes, which relative(s):_____

List all herbal medications/supplements that you currently take:

_____ _____ _____ _____

_____ _____ _____ _____

List all medications that you currently take:

_____ _____ _____ _____

_____ _____ _____ _____

List all known allergies and reaction (please explain):

_____ _____ _____ _____

_____ _____ _____ _____

Social History

Smoking Status (please circle one)

Current Smoker Former Smoker Never Smoker

Number of packs per day_____ Date Quit Smoking_____

Do you drink alcohol? No Yes If yes, how many drinks per week? _____

Do you use recreational drugs? No Yes If yes, which? _____

Do you exercise? No Yes If yes, how often? _____

Occupation _____

Any other family history of major medical problems? (i.e., Diabetes, heart disease, asthma, cancer, etc….)

_____

_____

Pharmacy

Name:_____

Street Address:_____ City:_____ Zip Code:_____