

SPOKANE CENTER FOR FACIAL PLASTIC SURGERY

Date: _____
Patient Name: _____ Birth Date: _____
Referring Physician: _____ Family Doctor: _____

GENERAL INFORMATION

Male [] Female [] Marital Status M [] S [] D [] W []

Occupation _____ Disabled []

Smoking History:

[] I have never smoked [] I am exposed to smoke at work
[] I currently smoke Years _____ Packs per day _____
[] I previously smoked Quit date _____ Years Smoked _____

Other: _____
Does anyone in the home smoke? Yes [] No []

Alcohol use: Yes [] No [] Drinks per day: _____

Recreational Drug use: Yes [] No [] Type: _____

Females: Any chance you could be pregnant? Yes [] No [] Date Last Period: _____

If the patient is a child, are they in daycare? Yes [] No []
If so, how many days per week? _____ Child's grade in school: _____

SURGERIES

Have you ever had surgery? Yes [] No [] If yes, complete the following:

Table with 3 columns: Name of Surgical Procedure, Date of Surgery, Surgeon. Multiple rows for listing procedures.

Did you have any complications from surgery? Yes [] No [] Explain: _____
Have you ever been hospitalized other than for surgery? (Include child birth) Yes [] No []

Reason _____ Date _____

MEDICATIONS

List all medications you are taking (with doses):

MEDICATION ALLERGIES

List Medication Allergies and Reactions:

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- I have no Medical Problems
- I have no Family History of Medical Problems
- No History Available

Please Check the boxes below if you or a relative (Parent or Sibling) have or have had the disease or disorder.

Disease or Disorder	Patient ↓	↓ Parent or Sibling
Heart Disease/Problems		
Chest Pain		
Heart Attack		
High Blood Pressure		
Irregular Heart Beat		
Heart Murmur		
Pacemaker		
Poor Circulation		
High Cholesterol		
Reflux/Heartburn		
Hiatal Hernia		
Bowel Disorder		
I.B.S. (Irritable Bowel)		
Ulcer		
Hepatitis		
Liver Disorder		
Crohns Disease		
Colitis		
Arthritis		
TMJ		
Fibromyalgia		
Osteoporosis		
Neck/Back Disorder		
Neurological Disease		
Stroke		
Seizure		
Loss of Consciousness		
Multiple Sclerosis (MS)		
Memory Loss		
Headaches		
Alzheimers		
Parkinsons Disease		
Urticaria		
Angioedema/Hives		
Rashes/Lesions		
Lupus		
Hay Fever/Seasonal Allergy		
Glaucoma		

Disease or Disorder	Patient ↓	↓ Parent or Sibling
Cataract		
Macular Degeneration		
Visual Impairment		
Hearing Impairment		
Emphysema/COPD		
Asthma		
Snoring		
Tuberculosis (TB)		
Shortness of Breath		
Sleep Apnea		
Use Oxygen		
Pneumonia		
Bladder Problems		
Kidney Failure/Problems		
Dysuria (Painful Urination)		
Enlarged Prostate		
Polyuria (Frequent Urination)		
Hypoglycemia		
Diabetes		
Thyroid Disorder		
Goiter		
Anemia		
HIV/AIDS		
Bleeding Problems		
Nose Bleeds		
Anxiety		
Depression		
Mental Disease		
Stress		
Recent Life Crisis		
Cancer (List under "Other")		
ADHD		
Autism		
Bipolar Disorder		
Cerebral Palsy		
Dementia		
Down Syndrome		
Anesthetic Problems		

On CPAP?

Are you now taking?:	Y	N
Anticoagulants/Blood thinners		
Anti-Inflammatory Medications		
Aspirin		
Coumadin		
Insulin		

Other: _____

(OVER)

Patient Name: _____

SPOKANE CENTER FOR FACIAL PLASTIC SURGERY PATIENT INFORMATION

LAST NAME		FIRST		MIDDLE	
SOCIAL SECURITY#		BIRTHDATE		MALE	
FEMALE		MAILING ADDRESS APT		CITY	
STATE		ZIP CODE			
HOME PHONE		WORK PHONE		CELL PHONE	
EMPLOYER		OCCUPATION		REFERRING PHYSICIAN (FIRST AND LAST NAME)	
FAMILY DOCTOR (FIRST AND LAST NAME)					

SPOUSE'S INFORMATION

SPOUSE'S NAME		SOCIAL SECURITY NUMBER		DATE OF BIRTH	
EMPLOYER		OCCUPATION		WORK PHONE	

***** EMERGENCY CONTACT NOT LIVING WITH THE PATIENT *****

NAME		RELATIONSHIP		PHONE NUMBER	
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COMPLETE IF PATIENT IS A MINOR OR IS COVERED BY A PARENT'S INSURANCE

<u>FATHER</u> OR GUARDIAN LAST NAME		FIRST NAME		SOCIAL SECURITY NUMBER	
DATE OF BIRTH		HOME PHONE		WORK PHONE	
<u>MOTHER</u> OR GUARDIAN LAST NAME		FIRST NAME		SOCIAL SECURITY NUMBER	
DATE OF BIRTH		HOME PHONE		WORK PHONE	

MEDICAL INSURANCE

INSURANCE COMPANY		ID #		GROUP #	
SUBSCRIBER NAME		SUBSCRIBER SOCIAL SECURITY NUMBER		SUBSCRIBER DATE OF BIRTH	
EMPLOYER		SUBSCRIBER ADDRESS		SUBSCRIBER PHONE	
RELATIONSHIP TO PATIENT					

SECONDARY MEDICAL INSURANCE

INSURANCE COMPANY		ID #		GROUP #	
SUBSCRIBER NAME		SUBSCRIBER SOCIAL SECURITY NUMBER		SUBSCRIBER DATE OF BIRTH	
EMPLOYER		SUBSCRIBER ADDRESS		SUBSCRIBER PHONE	
RELATIONSHIP TO PATIENT					

WILL THIS CLAIM BE COVERED BY STATE INDUSTRIAL? YES NO NOTIFY RECEPTIONIST PRIOR TO APT. IF YES

I certify that I am the patient or duly authorized general agent of the patient able to furnish the information requested. I acknowledge that the charges incurred by my dependent(s) or me are my responsibility. I acknowledge the 1.5% per month finance charge if my account is not paid in full after 60 days. I also request assignment of insurance benefits to Spokane Ear, Nose & Throat Clinic, P.S. **Deductible and/or copayment are due at the time of service.**

I acknowledge that Spokane Ear, Nose & Throat Clinic reserves the right to charge \$25 for Non-Sufficient Fund Checks, missed appointments or appointments cancelled without 24 hour advance notice.

RESPONSIBLE PARTY SIGNATURE		RELATIONSHIP TO PATIENT		DATE	
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