MICHAEL D. **STORCH**, M. D.
ANDRES **SARRAGA**, M. D.

Plastic and Reconstructive Surgery

Name:_____Date:_____Age:_____

Date of Birth:_____Social Security No.:_____

Circle: Male/Female Marital Status: Single/Married/Divorced/Widowed

Local Address:_____
City:_____State:_____Zip:_____

Permanent Address:_____
City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____E Mail:_____

Patient's Occupation:_____
Employer:_____
Address:_____Phone:_____

Spouse's Name (Parents Name if Patient is a Minor):_____
Occupation:_____Employed By:_____
Address:_____Phone:_____

INSURANCE INFORMATION

Please Note Cosmetic Procedures are Generally Not Covered by Most Insurance

Responsible Party or Spouse_____

Primary Insurance_____
Policy #_____

Secondary Insurance_____
Policy #_____

Reason for Consultation:_____
Referred By:_____

May We Send a Thank You Not to the Person (s) Who Referred You? Yes___No___

Name: _____ Date: _____

Primary Care Physician: _____
Address: _____
City_____ State_____ Zip_____
Phone_____

Cardiologist_____ Phone:_____
Opthalmologist_____ Phone:_____
Dermatologist_____ Phone:_____

MEDICAL DATA: Height_____ Weight_____

DO YOU OR HAVE YOU HAD: (Circle and give date of occurrence)

Heart Murmur	No	Yes	Glaucoma	No	Yes
Seizure Disorder	No	Yes	Dry Eyes	No	Yes
Thyroid Disorder	No	Yes	Asthma	No	Yes
Bleeding Disorder	No	Yes	Diabetes	No	Yes
Cold Sores	No	Yes	Bruisability	No	Yes
Abnormal Scars (Keloids)	No	Yes	Stroke	No	Yes
High Blood Pressure	No	Yes	Blood Clots	No	Yes
Irregular Heartbeat	No	Yes	Phlebitis	No	Yes
Immune System Disorder	No	Yes	Arthritis	No	Yes
Blood Transfusions	No	Yes	Other_____		
Hepatitis	No	Yes	Malignant Hyperthermia Family History	No No	Yes Yes

Date of Previous Surgeries, Serious Illnesses or Injuries (Including Any Cosmetic Procedures):_____
_____
_____Any Complications?_____

Number of Pregnancies:_____Any Complications?_____

Allergies & Sensitivities;_____

Medications & Vitamins You Currently Take:_____

Do You Drink Alcohol? No Yes Frequency_____

Do You Use Recreational Drugs? No Yes Frequency_____

Do You Smoke? No Yes Amount:_____Did You Ever Smoke?_____
Date Stopped_____

Please Note – Smoking Increases the Risk of Surgery!