FRISCO PLASTIC SURGERY, P.A.

(972) 334-0400

Patient Information

Fill in or correct all fields

Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? No☐ Yes☐ If yes, contact restrictions: _____

Email: _____ Drivers License # and State _____

Age _____ Birthdate _____ Gender Female☐ Male☐

Marital Status: Single☐ Married to:☐ _____ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes☐ No☐

Address _____
Street & Suite # City State Zip

Responsible Party (if different from patient):

Name of spouse or parent if Patient is a minor _____ Relationship to Patient _____

Address _____ Home Phone _____

Emergency Contact

_____ Relationship to Patient _____

Home Phone _____ Cell Phone _____ Other Phone _____

Reason for today's visit _____

How did you hear about Dr. Smart?

☐ Frisco Style ☐ Snapchat ☐ Instagram ☐ Facebook ☐ kensmartmd.com
☐ Starwood Magazine ☐ D Magazine ☐ Word of Mouth ☐ Other: _____

Friend/Relative: _____ Doctor: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

Payment Policy: Payment is due in full at the time services are rendered.

Assignment of Benefits: I hereby assign all medical and/or surgical benefits to which I am entitled, including private insurance and any other health plans, to Frisco Plastic Surgery, P.A.. I transfer my title of reimbursement from my insurance company to Dr. Smart of Frisco Plastic Surgery, P.A.. I authorize Dr. Smart to bill my insurance company for medically necessary services. I authorize my insurance claim form to be sent via electronic filing. I authorize said assignee to release all information necessary to secure payment. I authorize the release of my medical records or insurance claims to be sent via fax. **Regardless of insurance coverage, I am responsible to pay any and all charges that exceed or that are not covered by insurance.** This assignment will remin in effect until revoked by me in writing. A photocopy of this assignement is to be considered as valid as an original.

Signature _____ **Date** _____

FRISCO PLASTIC SURGERY, P.A.

(972) 334-0400

6898 Lebanon Rd. Suite 102 , Frisco, Tx 75034-7474

Health Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient:			
DOB	Age	Marital Status	Weight lbs
What surgery are you considering?			Height ft in

DO YOU NOW OR HAVE YOU EVER HAD…….. (You must circle an answer for each individual item)

Glaucoma, Cataracts or other Eye Problems	Yes	No	Shortness of Breath	Yes	No
Stroke	Yes	No	Asthma	Yes	No
Seizures, convulsion or fainting spells	Yes	No	Pneumonia or Frequent Bronchitis	Yes	No
Palsy or Paralysis	Yes	No	Tuberculosis	Yes	No
Nervous Breakdown, Nervous Disorder	Yes	No	Emphysema	Yes	No
Self-Destructive Tendencies	Yes	No	Coughing, Spitting or Vomiting of Blood	Yes	No
Psychiatric Hospitalization or Care	Yes	No	Thyroid Problems	Yes	No
Alcoholism or Drug Dependency	Yes	No	Kidney or Renal Disease	Yes	No
Esophageal Varices	Yes	No	Dialysis Treatment	Yes	No
Airway Obstruction (Nasal)	Yes	No	Gallstones or Gallbladder Trouble	Yes	No
Major Allergies	Yes	No	Yellow Jaundice or Liver Disease	Yes	No
Dentures, bridges, crowns or capped teeth	Yes	No	Positive Blood Test for: HIV, AIDS or Hepatitis	Yes	No
Cosmetic bonding to teeth or loose teeth	Yes	No	Diabetes	Yes	No
Heart Disease	Yes	No	Kidney, Bladder or Prostate Issues	Yes	No
Heart Attack	Yes	No	Cancer	Yes	No
Palpitations or Irregular Pulse	Yes	No	High Cholestrol	Yes	No
Abnormal EKG	Yes	No	Rheumatic Fever	Yes	No
Chest Pain	Yes	No	Skin Disorders	Yes	No
Congestive Heart Failure	Yes	No	Arthritis, Bone or Joint Disorders	Yes	No
Heart Murmur	Yes	No	Fracture of Neck or Spine	Yes	No
Hypertension	Yes	No	Breast Cysts, Tumors, Abscesses	Yes	No
Blood Pressure Abnormalities	Yes	No	Nipple Discharge (Apart from Normal Lactation)	Yes	No
History of DVT	Yes	No	Insomnia	Yes	No
Bleeding Tendency or Clotting Disorder	Yes	No	Piercing other than ears	Yes	No
Blood Transfusion	Yes	No	Missed or Irregular last menstrual period	Yes	No
Abnormal Bleeding after Tooth Extraction	Yes	No	Family history of Cancer, Heart Trouble or Stroke	Yes	No
Frequent Indigestion	Yes	No	Any family members with anesthesia problems	Yes	No
Ulcers	Yes	No	Family history of unexplained death after anesthesia	Yes	No
Gastritis	Yes	No	Family or Personal History of		
Colitis	Yes	No	Malignant Hypothermia (MH)	Yes	No
Tarry/Bloody Bowel Movements	Yes	No	Personal history of muscle spasms, dark urine or		
Hemorrhoids	Yes	No	Fever immediately following anesthesia or exercise	Yes	No
Constipation	Yes	No	Any family members with bleeding problems	Yes	No

1. **Please list all present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. **Include over-the-counter medications.**

   _____

   _____

2. Do you have an allergic reaction to any medication? ❒ Yes ❒ No Which? _____

3. Do you react abnormally to any medication? ❒ Yes ❒ No Which? _____

4. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?

❒ Yes ❒ No If yes, when and where? _____

5. Have you ever been on cortisone or steroid treatment? ❒ Yes ❒ No When? _____

6. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?

❒ Yes ❒ No If so, how much? _____

7. Do you smoke? ❒ Yes ❒ No If so, how much? _____ For how long? _____

8. Are you pregnant? ❒ Yes ❒ No When was you last normal menstrual period? _____

9. How many pregnancies? _____ Births? _____ Breast Fed? ❒ Yes ❒ No How long? _____

CHILDREN (list names and ages/birthdays): _____

_____

10. When was your last physical exam? _____ By whom? _____

11. When was your last eye examination? _____ By whom? _____

12. When and where was your last chest x-ray? _____ EKG? _____

13. Who is your personal physician, if any? _____Please list all physicians presently caring for you.

_____

14. Have you ever been under psychiatric care? ❒ Yes ❒ No When? _____Why? _____

15. Have you had any recent blood work done? ❒ Yes ❒ No Where? _____

16. Is there anything else you think the doctor should know? _____

_____

17. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:

SURGICAL OPERATIONS (include where, when and why for each surgery): _____

_____

_____

_____

HOSPITALIZATIONS (include where, when and why for each admission): _____

_____

_____

By signing below, I agreee that the above information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____