



14256 N. Northsight Blvd., Suite 120 ♦ Scottsdale, AZ 85260
Phone: (480) 657-2000 ♦ Fax: (480) 657-2011

1331 N. 7th Street, Suite 170 ♦ Phoenix, AZ 85006
Phone (602) 368-2547 ♦ Fax: (602) 368-3218

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ MALE FEMALE

Street Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Date of Birth: _____ Email Address: _____

Marital Status: SINGLE MARRIED DIVORCED WIDOWED

Employer: _____ Occupation: _____

How did you hear about us? _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Contact # _____

REASON FOR CONSULT

<input type="checkbox"/> Breast Enlargement	<input type="checkbox"/> Breast Lift	<input type="checkbox"/> Breast Reduction	<input type="checkbox"/> Breast Reconstruction	<input type="checkbox"/> Implant Exchange
<input type="checkbox"/> Tummy Tuck	<input type="checkbox"/> Liposuction	<input type="checkbox"/> Body Lift	<input type="checkbox"/> Body Contouring after Massive Weight Loss	
<input type="checkbox"/> Facelift	<input type="checkbox"/> Eyelid Lift	<input type="checkbox"/> Neck Lift	<input type="checkbox"/> Rhinoplasty	<input type="checkbox"/> Otoplasty
<input type="checkbox"/> Skincare	<input type="checkbox"/> Radiesse	<input type="checkbox"/> Restylane/Perlane	<input type="checkbox"/> Botox/Dysport	<input type="checkbox"/> Chemical Peel
<input type="checkbox"/> Scar Revision	<input type="checkbox"/> Other: _____			

INSURANCE INFORMATION

Primary Insurance Company _____ Insurance Phone #: _____

Policy #: _____ Group #: _____ Employer: _____

Insured Name: _____ Insured DOB: _____

Secondary Insurance Company _____ Insurance Phone #: _____

Policy #: _____ Group #: _____ Employer: _____

Insured Name: _____ Insured DOB: _____

HEALTH & MEDICAL INFORMATION

Primary Care Physician: _____ Phone #: _____

Age: _____ Height: _____ Weight: _____ BMI: _____ (for office use only)

Have you ever smoked? Yes No * If yes, _____ packs/day for _____ year(s). Do you still smoke? Yes No

How much alcohol do you drink? _____ Drinks per: day week month

How much caffeine do you drink? _____ Drinks per: day week month

List the dates of your most recent:

Physical: _____ Normal? Yes No EKG: _____ Normal? Yes No

Chest X-Ray: _____ Normal? Yes No Blood Work: _____ Normal? Yes No

WOMEN ONLY:

How many pregnancies have you had? _____ How many children have you born? _____ How many C-Sections? _____

Is there a chance that you are currently pregnant? Yes No Date of most recent breast exam: _____

Are you having regular menstrual periods? Yes No Date of most recent mammogram: _____

Do you experience heavy bleeding with your periods? Yes No

ADDITIONAL HEALTH & MEDICAL INFORMATION

MEDICATIONS: Please list all the medications you are currently taking, prescription and non-prescription, supplements, vitamins, diet pills and those medications you make take on an as needed basis. Please also include the dose of the medication.

MEDICATION & DOSAGE

ALLERGIES: Please list all allergies to medications, tape, latex, iodine, etc. and the reaction that you have when exposed.

	<input checked="" type="checkbox"/> I HAVE NO KNOWN DRUG ALLERGIES

SURGICAL HISTORY:

Please list any surgeries and/or serious accidents or injuries. Please include the date of the surgery, accident or injury.

Have you and/or any of your family members had any history of anesthesia complications? Yes No

If yes, please describe: _____

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS: Please check all that apply to YOU.

NEUROLOGICAL	BLOOD	PULMONARY	CARDIOVASCULAR	SKIN/IMMUNE
<input type="checkbox"/> Migraines	<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Arthritis/Joint Pain
<input type="checkbox"/> Stroke	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Back/Neck Pain
<input type="checkbox"/> Seizures	<input type="checkbox"/> Blood Clots/DVT	<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Skin Disorder(s)
<input type="checkbox"/> Head Injury	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> COPD	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Autoimmune Disorders
<input type="checkbox"/> Depression	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Pulmonary Embolism	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Lupus/Scleroderma
	<input type="checkbox"/> Prior Transfusion		<input type="checkbox"/> Swollen extremities	<input type="checkbox"/> Pigmentation Issues
			<input type="checkbox"/> Palpitations	
GENERAL	HEAD/NECK	ENDOCRINE	GASTROINTESTINAL	ALLERGY
<input type="checkbox"/> Fever	<input type="checkbox"/> Change in vision	<input type="checkbox"/> Heat/Cold Intolerance	<input type="checkbox"/> Constipation	<input type="checkbox"/> Tape Allergy
<input type="checkbox"/> Weight Loss/Gain	<input type="checkbox"/> Nasal blockage	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Reflux disease	<input type="checkbox"/> Environmental
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Iodine Allergy
<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Sinusitis		<input type="checkbox"/> Hepatitis/Jaundice	<input type="checkbox"/> Latex Allergy
	<input type="checkbox"/> Wear contacts/glasses		<input type="checkbox"/> Frequent Urinary Infections	
			<input type="checkbox"/> Hernia	
<input type="checkbox"/> CANCER: (TYPE)		<input type="checkbox"/> OTHER:		<input checked="" type="checkbox"/> NONE OF THE ABOVE

FAMILY HISTORY: Please check those that apply to your family members:

<input type="checkbox"/> Blood clots/DVT	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Asthma	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Stroke
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other	<input checked="" type="checkbox"/> NONE OF THE ABOVE

The above information is accurate and complete to the best of my knowledge.

Patient Signature

Date

FOR OUR INSURANCE PATIENTS: Payment Authorization Notice and Release of Information

I understand that visit charges are payable on the day service is rendered. I authorize Arizona Plastic & Reconstructive Surgeons, PLLC to bill my insurance company for medically necessary services. Regardless of insurance coverage, I understand that I am financially responsible for charges not covered by this authorization, including deductibles and co-pays. Furthermore, I hereby authorize Arizona Plastic & Reconstructive Surgeons, PLLC, to release such information in connection with this treatment to my insurance company and/or hospital benefits program, which is necessary for payment by same. I understand this contract is between me and Arizona Plastic & Reconstructive Surgeons, PLLC.

Patient Signature

Date