

Health History

Name: _____ Birthday: _____ Date: _____

Social: Age _____ Sex: Male Female Marital Status _____ Occupation _____

Responsible Adult to Assist During Recovery Period _____ Relationship _____

Habits: Do you, or have you ever used any drugs for recreational purposes? **Yes/ No** Marijuana **Yes/ No** Cocaine **Yes/ No** Methamphetamines **Yes/ No** Other (specify): _____

Do you smoke? **Yes/ No** If yes, how long? _____ How much? _____

Did you ever smoke? **Yes/ No** If yes, How long? _____ How much? _____

Describe your alcohol consumption (How many drinks each day/week) _____

Describe your coffee/tea/cola consumption (How many each day/week) _____

Medications you are presently taking: None OR, list dosage and how frequently you take the medicine

Prescription Drugs

Non-Prescription (Vitamins; Herbs)

Are you or have you taken:

Aspirin **Yes/ No** Dosage and Frequency: _____

Accutane in the last 6 months **Yes/No** Dosage and Frequency: _____

NSA (Advil, Motrin, Ibuprofen, Aleve, Relafen, Naprosyn) **Yes/ No** Dosage and frequency: _____

Steroids or Cortisone Injections **Yes/ No** Dosage and Frequency: _____

Coumadin or Plavix **Yes/ No** Dosage and Frequency: _____

Anti-depressants **Yes/ No** Dosage and Frequency: _____

Allergies: None OR, please list any medications you are allergic to: _____

Are you allergic to: Adhesive tape? **Yes/ No** Iodine? **Yes/ No** Latex? **Yes/ No**

FOR WOMEN ONLY: Do you take estrogens (creams, shots, pills) or birth control pills? **Yes/ No** If "Yes"

Specify: _____

Family History

Have any blood relatives ever had any of the following problems? (circle)

Abnormal Bleeding **Yes/ No** Coronary Surgery **Yes/ No** Kidney Disease **Yes/ No**

Abnormal Clotting **Yes/ No** Diabetes **Yes/ No** Other Serious Illness **Yes/ No**

Anesthesia Problems **Yes/ No** Heart Attack **Yes/ No**

Cancer **Yes/ No** Hypertension **Yes/ No**

Please describe questions with a "Yes" answer: _____

What is the purpose of this consultation (describe what you would like corrected by plastic surgery and what our aesthetic goals are in regard to your desired correction)? _____

Have you ever consulted a plastic surgeon? **Yes/ No** (Please Describe) _____

Have you ever had plastic surgery? **Yes/ No** (Please Describe): _____

Have you ever been in litigation with a physician? **Yes/ No** (Please Describe): _____

Personal Past History

Past Operations: None OR, list any past operations with the approximate date of surgery, your age at the time of operations, and name of the physician and hospital (include minor operations such as tonsillectomy)

Past Illnesses/ Hospitalizations: No serious past illnesses OR, list below with age:

Age	Illness/ Hospitalization

Date	Age	Operation	Physician and Hospital

Have you ever had:

Abnormal bleeding **Yes/ No** Diabetes **Yes/ No** Snoring **Yes/ No**
Abnormal clotting **Yes/ No** Fainting Spell **Yes/ No** Weight Change past 12 Mo **Yes/ No**
Acid Regurgitation **Yes/ No** Heart Attack **Yes/ No** Other Serious Illness **Yes/ No**
Anemia **Yes/ No** Hepatitis **Yes/ No**
Angina **Yes/ No** Hypertension **Yes/ No**
Asthma or Bronchitis **Yes/ No** Sleep Apnea **Yes/ No**

Please describe questions with a "Yes" answer: _____

Preoperative Screening: Adverse effect to any anesthesia? **Yes/ No** If "Yes" please specify: _____

Do you wear:

Eye Glasses: **Yes/ No** Hearing Aid: **Yes/ No** Partials: **Yes/ No** If "Yes", Removable **Yes/ No**
Contact Lenses: **Yes/ No** Dentures: **Yes/ No**

Do you have: Caps: **Yes/ No** Veneers: **Yes/ No**

Are you in good health? **Yes/ No** Do you heal well? **Yes/ No**

Do you have long-standing emotional disorders? **Yes/ No**

Do you have a physician you call or visit for medical problems? **Yes/ No**

Name: _____ Address: _____

Phone: _____ May I consult, if necessary, with your physician? **Yes/ No**

Are there any additional health factors in you history that have not been covered in this medical history form?

Who may we thank for referring you to our office? _____

AUTHORIZATION FOR EXAMINATION AND TREATMENT

Name: _____ **Birth date:** _____

Address 1: _____ **SS #:** _____

Address 2: _____ **Home Phone:** _____

City: _____ **State:** _____ **Zip:** _____

Work Phone: _____

Insurance: Yes() No() **Source:** _____

I, _____, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if no, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistant or staff as may be assigned by him/her.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. In the event of any litigation arising from treatment, I agree to submit the case to arbitration. I understand that photography is a necessary part of planning and evaluating aesthetic or reconstructive surgery. I authorize photographs to be taken at the direction of my surgeon and under such conditions as he may approve. These photographs shall be used solely for educational and/or documentation purposes and shall be kept confidential.

I understand that there may be a consultation fee for the initial visit which is due at the time of my appointment.

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP: (circle one) PATIENT SPOUSE PARENT GUARDIAN

Aesthetic Plastic Surgical Institute, Inc. strives to maintain high standards of confidentiality over your health care information. As such, we feel it is important to ask you to designate your preferences in disclosing your health care information.

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care options). If none, please indicate so.

2. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name _____ Phone # _____
Name _____ Phone # _____

3. Please print the address you would like your billing statements and/or correspondence from our office to be sent if other than your home.

Street _____
City, State, ZIP _____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL": Yes _____ No _____

5. Please print the telephone number where you want to receive calls about your appointments, lab and ex-ray results, or other health care information if other than your home number:

(I am fully aware that a cell phone is not a secure and private line)

6. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail? Yes _____ No _____

7. Please list an identifying password to verify identity should you call in to get your patient information. (Examples include your mother's maiden name or another word that you will remember.) Also, you could list a question that would enable you to cue that word, if you so desire.

PATIENT NAME _____ *(guardian if under 18 years)*

PATIENT/GUARDIAN SIGNATURE

DATE

Acknowledgement of Receipt of Notice of Privacy Practices

Daniel C. Mills, M.D. reserves the right to modify the privacy practices outlined in the notice.

*Notice is posted in waiting room and reception area.

*Copy available upon request.

Signature _____

**I have a read copy of the Notice of Privacy Practices for
Daniel C. Mills, M.D.**

Name of Patient (Print)

Signature of Patient

Date

Signature of Patient representative

(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

Patient Registration Form

Name: _____ Birthday: _____ Age: _____ Gender: _____

Current Address: _____ Marital Status: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Home Phone: _____

e-mail Address: _____ Cell Phone: _____

Would You Like to Receive the e-Newsletter Yes No What is your preferred method of contact? _____

Referred to Dr. Mills by: Biomedic McGhan Dr. Mills' Employee _____

Physician _____ Hospital _____

Patient Name _____ Seminar _____

Salon _____ Media. Circle One: Article - Publication - Mailer _____

Internet (Which Site) _____ Work Phone: _____

Employer: _____

Employer's Address: _____ City: _____

State: _____ Zip: _____

Responsible

Name: _____ DOB: _____ Relationship: _____

Address: _____ SSN: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Address: _____

Insurance

Insurance Company Name: _____

Address: _____ State: _____ Zip: _____

Benefits #: _____ Preauthorization #: _____

Insured's Name: _____

Insured's Address: _____

Policy #: _____ Group #: _____

Medicare #: _____ Medical #: _____

Insured's Signature: _____ Date: _____

- I hereby authorize Doctor Mills and / or Aesthetic Plastic Surgical Institute, Inc. to release any information regarding services rendered by him and allow a photocopy of my signature to be used to file insurance claim[s].
- I also hereby authorize and direct payment check[s] to for benefits due to me for the services rendered by Doctor Mills and to be made directly to him and / or Aesthetic Plastic Surgical Institute, Inc. and Oceanview Ambulatory Surgery Center. I understand I am financially responsible for all fees for the services rendered regardless of my insurance benefits, if any.
- I consent to be photographed before, during, and after the treatment[s]. These photographs and negatives will be the property of Aesthetic Plastic Surgical Institute, Inc. and may be used for scientific and / or educational presentations or publications.
-

Signature [patient, parent/guardian] Date: _____