Plastic and Reconstructive Surgery Specialists, LLC

Patient Information

Please fill out our confidential Patient Health Record completely and accurately.

Name: First ______________________Middle initial_____ Last__________________________________

Street _______________________________________Town_________________________State_____ Zip___________

Age:_______ Date of birth:_____/______/_______SS#: _______-______-_________ Gender:____________________

Please provide all contact numbers to ensure timely communication of important information.

Cell ( ) ________-__________ Home ( ) ________-__________ Work ( ) ________-___________

Email ____

Emergency Contact: ( ) ________-__________ Name: ________________________________

Your privacy is of the utmost importance to us. Please indicate if there are any restrictions in contacting you:
____

Occupation (current or prior to retirement/disability):____

Address of current employer: ____☐ NA

Primary care physician: ________________________________Tele: ( ) ________-__________

Referred by: ☐ Physician_________________________ ☐ Friend/Family___________________________________

☐ Internet/Website ☐ Emergency Room (Location) _______________________

☐ Newspaper/brochure ☐ Seminar/other__________________________________

Have you visited our website? ☐ Yes ☐ No If yes, suggestions for improvement?____________________________

Name of Primary insurance Co.: ______________________Policy#:___________________Group#_______________

Name of Secondary Insurance Co.: ____________________Policy#:___________________Group#______________

Policy Holders Information (*if other than patient*)

Name: _________________________________ D.O.B:_____/______/______ Relationship to patient: ___________

Street Address____City_________________________State________

Phone number: ( ) ________-___________

Authorization to Release Information: I authorize Dr. John Reilly and Plastic and Reconstructive Surgery Specialists, LLC to release any information necessary, acquired in the course of my treatment, to process insurance claims. I further authorize my insurance company to pay Dr. John Reilly and Plastic and Reconstructive Surgery Specialists, LLC directly for medical service rendered. I understand that I will be responsible for non-covered charges, balances after insurance company benefits, deductibles and copayments.

Signature (Patient/Guardian) ____ Date: ______/______/_______

Name: First ____________________ Last:________________________________

Date of Birth: ______/______/_______

Height: ____ feet ______ inches Weight: ________ pounds

Detailed reason for visit (including left or right, specific finger or body part):

____

Has this condition been diagnosed/treated by another physician?☐ No ☐ Yes_____ (If yes, where?)

____

Past Medical History:

Do you have currently, or have been treated for any of the following?

	Yes	No		Yes	No
Tuberculosis	___	___	HIV disease	___	___
Diabetes	___	___	Hepatitis	___	___
Coronary artery disease	___	___	Hypertension	___	___
Skin cancer	___	___	COPD	___	___
Poor circulation	___	___	Leg vein problems	___	___
Stroke	___	___	High cholesterol	___	___

Other: ____________________________ ________________________

Review of Systems: Have you had or currently have any of the following:

Constitutional	Yes	No	Cardiovascular	Yes	No
Unexplained weight loss?	___	___	Chest pain	___	___
Poor appetite	___	___	Palpitations	___	___
Fever	___	___	Short of breath	___	___
Fatigue	___	___	Ankle swelling	___	___
Chills or sweats	___	___	High blood pressure	___	___

Eyes, Ear, Nose, Throat

	Yes	No
Dry eyes	___	___
Frequent nose bleeds	___	___
Trouble swallowing	___	___
Ringing ears	___	___

Respiratory

	Yes	No
Chronic cough	___	___
Difficulty breathing	___	___
Spitting blood	___	___

Gastrointestinal

Nausea or vomiting	___	___
Diarrhea	___	___
Constipation	___	___
Blood in stool	___	___

Hematologic

Easily bruised	___	___
Anemia	___	___
Prior transfusions	___	___
Blood Clot in leg ("DVT")	___	___

Neurologic

Hand/foot numbness	___	___
Limb weakness	___	___
Frequent headaches	___	___

Psychiatric

Anxiety	___	___
Depression	___	___
Paranoia	___	___

Skin (Integument)

Rashes	___	___
Ulcers	___	___
Change in "mole"	___	___
Bleeding lesion	___	___

Musculoskeletal

Joint pain	___	___
Bone pain	___	___
Hand/finger numbness	___	___

Family History: Has any family member of your family had the following?

Type — Member and their age at diagnosis

Cancer: ☐ No ☐ Yes ________________________ ____

Problems with anesthesia: ☐ No ☐ Yes (Define) ____

Social History:

Have you used tobacco in the past year? ☐ Yes ☐ NO If yes, how many cigs. per day? _____

How many alcoholic drinks do you consume per week? ______

Do you use recreational drugs? ☐ Yes ☐ No If yes, what type? ________________________

Medications:

If you have a printed list of your medications/surgeries the receptionist will be glad to make a photocopy to place in your chart. ☐ I provided a current list of medications to the receptionist.

Name of Medication	Condition being treated
__________________________	______________________________
__________________________	______________________________
__________________________	______________________________
__________________________	______________________________

Allergies to medication or Latex: ☐ No ☐ Yes If yes, list name of medication or Latex and type of reaction, i.e. rash, throat swelling, etc.

Allergic to:	Type of reaction:
__________________________	______________________________
__________________________	______________________________

Past Surgical History: ☐ I provided a written list of past surgeries to the receptionist.

Type of Surgery	Year	Type of Surgery	Year
______________________	________	_______________________	________
______________________	________	_______________________	________
______________________	________	_______________________	________
______________________	________		

Office use only: The patients Review of Systems, Past Medical, Family and Social history have been reviewed. Initials: ____________ Date _____/_____/_______

Acknowledgement of Receipt of Notice of Privacy Practices Plastic and Reconstructive Surgery Specialists, LLC

We are required to provide you with a copy of our *Notice of Privacy Practices*, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish. Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer at (203) 924 2900. Additional copies of the Privacy Practices can be obtained from our office staff or by visiting our website, ctplasticsurgeons.com.

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Plastic and Reconstructive Surgery Specialists, LLC

Name of patient:____

Signature of patient/guardian: ______________________________Date: ____/____/______

If not signed by patient, name of person signing and legal relationship to patient:

____

(please cirlce) parent conservator spouse

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ **The patient refused to sign.**
- ☐ **Due to an emergency situation, it was not possible to obtain acceptance.**
- ☐ **We weren't able to communicate with the patient.**
- ☐ **Other (*Please provide specific details*)**

____

________________________________ ________________

Employee Signature *Date*