

Bloom Facial Plastic Surgery
Two Town Place, Suite 110
Bryn Mawr, PA 19010

THIS PATIENT INFORMATION FORM IS PART OF YOUR MEDICAL RECORD AND MUST BE COMPLETED IN ITS ENTIRETY
PATIENT INFORMATION FORM

NAME _____
(Last) (First) (Middle)

SS# _____ BIRTHDATE _____ SEX: M F MARITAL STATUS: S M D W

HOME ADDRESS _____
(Street) (Apt) (City) (State) (Zip)

HOME PHONE _____ E-MAIL _____

WORK PHONE _____ CELL PHONE _____

OCCUPATION _____

EMPLOYER NAME _____

RESPONSIBLE PARTY INFORMATION: (IF OTHER THAN PATIENT)

NAME _____
(Last) (First) (Middle)

RELATIONSHIP TO PATIENT _____

SS# OF INSURED _____ BIRTHDATE OF INSURED _____

HOME ADDRESS _____
(Street) (City) (State) (Zip Code)

HOME PHONE _____

I HAVE NO INSURANCE COVERAGE (PLEASE CHECK IF APPROPRIATE)

REFERRED BY PHYSICIAN FRIEND INTERNET OTHER PHONE # _____

ADDRESS _____

PRIMARY CARE PHYSICIAN _____ PHONE # _____

ADDRESS _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

PHONE _____

I do hereby agree to pay the full and entire amount of the **consultation fee in addition to all bills for services rendered.**

(Sign Name) (Date)

As a member of a managed care group, I assume all responsibility for any services rendered that are not a part of my referral, whether or not covered or paid by my insurance, and **I will pay for those services at the time they are rendered.**

(Sign Name) (Date)

WORKER'S COMPENSATION AND OTHER PERSONAL INJURY TESTIMONY IN COURT

In order to provide the best possible service, care and availability to all of our patients, **it is our policy not to testify in court, depositions, arbitrations, etc. relating to Worker's Compensation and other personal injury action.**

(Sign Name) (Date)

Specialized Care

I understand that Bloom Facial Plastic Surgery Surgery is a tertiary referral practice. The physicians at our center will evaluate the specific problem for which you have been referred or have sought treatment. General otolaryngology or dermatology care and evaluation is the responsibility of the referring or primary physician. If you require a referral to an otolaryngologist or general dermatologist, please notify our office.

(Sign Name) (Date)

Reason for visit _____

How long have you had this problem? _____

Areas of Interest: (mark all that apply)

Cosmetic Procedures

- Rhinoplasty (Nose Reshaping)
- Chin or Cheek Implants
- Blepharoplasty (Eyelid Lift)
- Face or Neck Lift
- Midface Lift
- Brow or Forehead Lift
- Liposuction (Neck, Jowls)
- Otoplasty (Ear Pinning)
- Botox or Neurotoxins
- Injectable Fillers & Volumizers

- Lip Enhancement
- Facial Scars
- Double Chin / Kybella
- Earlobe Repair

Functional Procedures

- Nasal Obstruction
- Chronic Sinusitis
- Facial Nerve Spasm / Weakness
- Skin Cancer Repairs
- Nasal / Facial Fracture

Other Procedures

- Skin Care
- Lesions / Moles
- Telangectasia (spider veins)
- Skin Resurfacing (Laser, Peel, Etc.)
- Other _____

Have you ever been on Accutane? YES NO **If yes please also inform the doctor verbally**

If you were on Accutane when _____

Do you have or have a history of **Cold Sores**? NO YES

Do you have or have a history of Scarring or Keloids? NO YES

Have you recently had a hormonal work-up for excessive hair growth? NO YES If yes when _____

Do you have regular menstrual cycles? NO YES

Do/have you ever had permanent makeup/tattoos? NO YES **If yes please also inform the doctor verbally**

If yes where? Eyebrows Eyeliner Lip liner Other _____

Have you ever had Gold Therapy? NO YES **If yes please also inform the doctor verbally**

Are you pregnant at this time? NO YES

Do you faint when having blood drawn? NO YES

REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY OF PATIENT (CHECK ALL THAT APPLY; USE C. IF CURRENT, USE P IF PAST)

CONSTITUTIONAL SYMPTOMS:

- Fever Hair loss
- Weight loss Weight gain
- Chills Tremor
- Nutritional Deficiencies
- Other, specify _____

EYES:

- Cataracts Glaucoma
- Eyestrain Blurring
- Inflammation
- Wear glasses
- Wear contacts
- Other, specify _____
- Date of last eye exam _____

EARS, NOSE, MOUTH, THROAT:

- Hearing difficulty
- Pain Discharge
- Tinnitus (ringing in ears)
- Dizziness Wear hearing aid
- Sinusitis Postnasal drip
- Obstruction
- Gum Disease
- Chronic sores
- Herpes simplex infections
- Soreness Redness
- Hoarseness
- Other, specify _____

CARDIOVASCULAR:

- Stroke Palpitation
- Pacemaker Rheumatic Fever
- Faintness Pain
- High blood pressure
- Heart surgery
- Edema (swelling)
- Heart valve replacement
- Other, specify _____

INFECTIOUS:

- HIV Positive AIDS Virus
- Hepatitis

CANCER(S): (LIST TYPE, DATE, TREATMENT)

RESPIRATORY:

- Asthma Chest pain
- Emphysema Tuberculosis
- Lung disease
- Breathing disorder
- Bronchitis, chronic
- Sputum, with blood
- Cough, chronic
- Upper respiratory infection, chronic
- Other, specify _____

GASTROINTESTINAL:

- Ulcer Pain
- Nausea Constipation
- Diarrhea Vomiting
- Appetite decrease
- Colon/intestinal disorder
- Other, specify _____

GENTOURINARY:

- Discharge Urgency
- Sores Incontinence
- Hesitancy
- Herpes simplex infections
- Other, specify _____

MUSCULOSKELETAL:

- Arthritis Lupus
- Joint pain Lupus of the skin
- Weakness Joint swelling
- Joint replacement
- Cold sensitivity
- Other, specify _____

INTEGUMENTARY:

- Skin cancer(s)
- Acne Hives
- Warts Psoriasis
- Eczema Cystic Acne
- Loss of Pigment
- Contact dermatitis
- Malignant Melanoma
- Scarring/keloids
- Herpes simplex (cold sores)

- Herpes Zoster (shingles)
- Other, specify _____

NEUROLOGICAL:

- Headaches Convulsions
- Seizures Migraine
- headaches
- Epilepsy Fainting spells
- Memory loss
- Other, specify _____

PSYCHIATRIC:

- Stress Depression
- Nightmares Insomnia
- Anxiety Suicidal Tendency
- Treatment of psychological disorder
- Other, specify _____

ENDOCRINE:

- Thyroid disorder
- Diabetes mellitus
- Excessive hair, face/body
- Other, specify _____

HEMATOLOGIC/LYMPHATIC:

- Anemia Bruise easily
- Blood clots Excessive bleeding
- Other, specify _____

ALLERGIC/IMMUNOLOGIC:

- Asthma Frequent infections
- Allergies Thyroiditis
- Vitiligo Addison's Disease
- Pernicious anemia
- Hay Fever
- Other, specify _____

MALES ONLY:

- Urinary difficulties
- Prostatic problems

FEMALES ONLY:

- Chronic vaginal infections
- Currently pregnant
- Currently taking oral contraceptives
- Date of last menses _____

PATIENT INFORMATION FORM

THE PRACTICE FINANCIAL POLICY WILL BE GIVEN TO PATIENTS AT THE TIME OF REGISTRATION.
ALL PATIENTS MUST SIGN THIS FORM.

OUR PRACTICE FINANCIAL POLICY

The physicians and staff at our office are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made by either yourself or your health coverage carrier, full payment is due at the time of service. For your convenience, we accept Visa, MasterCard, American Express, Discover, Cash and Personal checks.

YOUR INSURANCE

We have made prior arrangements with some insurers and other health plans. We will bill those plans with whom we have an agreement and will collect any required co-payment at the time of service. The copayment will be collected when you arrive for your appointment. In the event your health plan determines a service to be not covered, you will be responsible for the complete charge. In that event, you will receive a statement at the time of service and payment is due at the time of service.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare a statement for you to attach to your insurance claim form for processing of payment. In this case, the insurance carrier will send the payment directly to you. Therefore, charges for your care and treatment are due at the time service is rendered.

Any balance due is your responsibility and is due upon receipt of a statement from our office.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

MISSED APPOINTMENTS

In order to provide the best possible service and availability to all our patients, we ask that you please call us as early as possible if you know you will need to reschedule your appointment.

I have read and understand the financial policy of the practice and I agree to be bound by its items. I also understand and agree that such terms may be amended from time-to-time by the practice.

(Signature of the Patient or Responsible Party)

(Date)

(Please Print the Name of the Patient)

Please fill out the following:

What medical/cosmetic issue would you most like to discuss today?

HOSPITALIZATIONS: None

Reason:	Dates:
1.	
2.	
3.	

PAST SURGICAL HISTORY: None

Surgery:	Dates:
1.	
2.	
3.	

MEDICATION / VITAMINS / HERBAL: None

Drug:	Reason:
1.	
2.	
3.	
4.	

Do you take aspirin or ibuprofen? YES NO
Blood thinners / Coumadin?

ALLERGIES TO MEDICATIONS: None

Drug:	Reaction:
1.	
2.	
3.	

Environmental/Contact/Food Allergies YES NO

If yes, which ones _____

Date of last medical check-up _____
Result _____

SOCIAL HISTORY: (Please indicate all that apply)

Consume alcohol excessively? YES NO
Have you ever smoked?
Used Cocaine?
Used recreational IV drugs?
Smoked Marijuana?

Surgeon's Notes:

Please fill out the following:

FAMILY HISTORY: *(Please indicate all that apply)*

	YES	NO
Reactions to anesthesia	<input type="checkbox"/>	<input type="checkbox"/>
Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding tendencies	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Clotting disorders	<input type="checkbox"/>	<input type="checkbox"/>

COSMETIC PROCEDURES:

Have you had any of the following?

	YES	NO
Botox / Dysport / Neurotoxins	<input type="checkbox"/>	<input type="checkbox"/>
Fillers (Juvederm/Restylane/Radiesse)	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Peel	<input type="checkbox"/>	<input type="checkbox"/>
Kybella	<input type="checkbox"/>	<input type="checkbox"/>
Laser Resurfacing	<input type="checkbox"/>	<input type="checkbox"/>
Rhinoplasty	<input type="checkbox"/>	<input type="checkbox"/>
Facelift / Necklift	<input type="checkbox"/>	<input type="checkbox"/>
Bleph (Eyelids) / Browlift	<input type="checkbox"/>	<input type="checkbox"/>
Liposuction	<input type="checkbox"/>	<input type="checkbox"/>
Chin / Cheek Implant	<input type="checkbox"/>	<input type="checkbox"/>
Facial Trauma / Plating	<input type="checkbox"/>	<input type="checkbox"/>
Facial Reconstruction	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any children? YES NO

How many?
How old?

List athletic activities:

List hobbies:

Have you ever been unhappy with the care of a physician? YES NO

If Yes, Explain:

Signature _____ Date _____

Surgeon's Notes: