SINGHAL PLASTIC SURGERY P.C.

9081 NE 81st Terrace, Kansas City, MO 64158
PHONE: (816) 429-7576 FAX: (800) 518 9514

National & Insurance Guide Lines require this to be filled out on a yearly basis.

TODAY'S DATE_____ APPOINTMENT WITH _____
(Doctor)

PATIENT'S NAME

_____
(Last) (First) (Middle) (Nickname)

DATE OF BIRTH_____ SEX: M ( ) F ( ) PATIENT'S SOCIAL SECURITY # _____

GUARDIAN NAME (if applicable)_____ RELATIONSHIP _____

ADDRESS_____ CITY_____ STATE_____ ZIP _____

HOME TELEPHONE (_____)_____ CELLULAR PHONE (_____) _____

I WILL ACCEPT TEXT APPOINTMENT REMINDERS TO MY CELL PHONE FROM SPS: YES OR NO

NAME OF NEXT OF KIN OR OTHER LOCAL CONTACT_____
TELEPHONE NUMBER _____

PATIENT'S EMPLOYER_____ PHONE (_____) _____

SPOUSE'S EMPLOYER_____ PHONE (_____) _____

WHO REFERRED YOU TO OUR OFFICE? _____

ADDRESS _____

PHONE (_____) _____

PRIMARY CARE PHYSICIAN_____

ADDRESS_____

PHONE (_____) _____

PRIMARY INSURANCE CO. _____

I.D. NUMBER_____ SUBSCRIBER'S NAME _____

GROUP NUMBER_____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER'S SOCIAL SECURITY #_____ SUBSCRIBER'S DATE OF BIRTH _____

SECONDARY INSURANCE CO. _____

I.D. NUMBER_____ SUBSCRIBER'S NAME _____

GROUP NUMBER_____ RELATIONSHIP TO PATIENT_____

SUBSCRIBER'S SOCIAL SECURITY #_____ SUBSCRIBER'S DATE OF BIRTH _____

INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize Singhal Plastic Surgery Inc. to furnish information to insurance carriers concerning illness and treatment rendered to the patient named below:

PATIENT NAME (printed) _____

PATIENT or GUARDIAN (signed) _____

Singhal Plastic Surgery, P.C.

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

Patient Name:_____ **DOB:** _____

Reason for today's visit:_____

Medications (Please include OTC medications and supplements. List dose and time of day taken):

_____

_____

_____

_____

Pharmacy Name and address: _____

Contraceptives/Hormones: _____

Allergies (include medications and environmental allergies. List type of reaction):

Tape: Y/N Iodine: Y/N Latex: Y/N

Other allergies:_____

Past Medical History (circle yes if you have currently or ever had in the past any of the following):

Bleeding disorder Y/N	Blood clots Y/N	High Blood Pressure Y/N
Heart disease/heart murmur Y/N	COPD/Asthma Y/N	Acid reflux/heartburn Y/N
Sleep apnea Y/N	Stroke/TIA Y/N	Seizure disorder Y/N
Hepatitis/Liver disease Y/N	HIV/AIDS Y/N	MRSA infection Y/N
Cancer Y/N	Diabetes Y/N	Thyroid disorder Y/N
Kidney disease Y/N	Keloid scarring Y/N	Poor or delayed healing Y/N
Blood transfusion Y/N	Adverse reaction to anesthesia Y/N	Mammogram Y/N

Surgeries and Hospitalizations (list all surgeries and hospitalizations, including cosmetic procedures and year of surgery):

_____

_____

_____

_____

Family History (circle yes or no; if yes, indicate which family member):

Bleeding disorders Y/N	Blood clots Y/N
Complications with anesthesia Y/N	Cancer (including melanoma) Y/N
High blood pressure Y/N	Coronary artery disease/Heart attack Y/N
Heart disease Y/N	Seizure disorder Y/N
Muscular dystrophy Y/N	Stroke/aneurysm Y/N
Cleft lip/palate Y/N	Diabetes Y/N

If yes to any of the above, list which family member affected _____

_____

Continued on back…

Social History:

Marital status: Single Married Lives with significant other /Partner Separated Divorced Widowed

Live with: _____Pets: _____

Employment status: employed unemployed retired student

Preventive Care: **Exercise**: Type/ how often _____ Immunizations: Up to date/ NOT up to date

Tobacco: have you ever used tobacco Y/N How much/how often?_____Quit? Y/N if yes, when?____

Alcohol: Y/N Type: _____ Number of drinks per week _____

Caffeine: Y/N Type: _____ Number of drinks per day _____

Recreational drug use: Y/N Type and frequency _____

Review of Systems (circle any of the following symptoms you have experienced in the past 3 months):

Fever	Unintentional weight gain/loss	Fatigue	Night sweats
Headaches	Nasal congestion/Runny Nose	Blurred vision	Glasses/contacts
Hearing Loss	Ear infection	Sore throat	Pain with swallowing
Cough	Shortness of breath	Wheezing	Chest Pain
Heart Palpitations	Swelling legs	Heart Murmur	Abdominal Pain
Diarrhea	Constipation	Nausea	Vomiting
Heartburn/GERD	Renal disease	Pain with urination	Blood in urine
Joint pain	Back pain	Muscle pain	Scoliosis
Numbness/tingling	Seizures	Weakness	Easy bruising
Easy bleeding	Depression	Anxiety	Rashes/Lesions

Females only: last menstrual period_____/____/_____ Are you currently Pregnant Y/N

Previous pregnancies: Full Term___Premature__ Stillbirth/Miscarriage____ Abortion___Total____

Physical Conditioning: I am unable to perform any of the following activities comfortably:

□ Washing car, walking at a pace of 1 mile/18 minutes
□ Shoveling snow, Mowing lawn, Walking at a pace of 1 mile/12-15 minutes
□ Jogging

Patient/guardian signature: _____ Date: _____

Reviewed with patient by: _____ Date: _____