SUMMIT
PLASTIC SURGERY
(912) 265-8988

PT ACCT# ________

(Please Print Legibly & Fill In or Correct All Fields)

Have you ever been seen by Dr. Paula Legere? ❒ No ❒ Yes, in what year? ____________

Patient's Name ______________________________
Last First Middle

Address ______________________________
Street & Apt # City State Zip

Home Phone ____________ Cell Phone ____________ Other Phone ____________

Any restrictions for contacting you? ❒ No ❒ Yes E-mail ____________

Age ______ Birthdate ___/___/___ SS# ___-___-___ Sex ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: ____________ ❒ Other: ____________

Name of Guarantor, if other than patient ______________________________
Last First Middle

Address if different from above ______________________________
Street City State Zip

Home Phone# ____________ Work Phone# ____________

Patient's Employer ____________ Occupation ____________

Work Phone ____________ Ext: ______ Is it okay to call you at work? ❒ Yes ❒ No

Emergency Contact
(Not in your household) ____________ Relationship to Patient ____________

Home Phone ____________ Cell Phone ____________ Work Phone ____________

Primary Health Insurance Company ______________________________

Policy # ____________ Group # ____________ Ins. Phone ____________

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ ______

Insured: Name ____________ DOB ____________ Employer ____________

Secondary Health Insurance Company ______________________________

Policy # ____________ Group # ____________ Ins. Phone ____________

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ ______

Insured: Name ____________ DOB ____________ Employer ____________

Family Physician ____________ Phone# ____________

Referred By (Patient or Physician) ______________________________

Or Circle One: Billboard Radio Website Word of Mouth Yellow Pages Internet Other Unknown

Specific Reason for Visit

____

I, ________________________, represent to the physician and staff that I am at least 18 years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and the treatment by my doctor and staff as may be assigned to her.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of any medical benefits directly to the doctor for services provided to me. ***I understand that insurance is filed as a courtesy. Any unpaid balance is my responsibility.*** In the event my account is placed with a collection agency, I understand that a collections fee of 33% will be added to my account. 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 cosmetic or reconstructive surgery. I authorize the taking of photographs at the direction of my surgeon and under such conditions as may be approved by her. These photographs will be used solely for documentation purposes and will be kept confidential.

I understand that there may be a consultation fee for the initial visit and if so, this fee will be due at the time of my appointment unless other arrangements have been made in advance.

Signature ____ **Date** ____________________

MEDICAL QUESTIONNAIRE:

CHIEF COMPLAINT / REASON FOR VISIT: ____
SERIOUS MEDICAL PROBLEMS: (please list)

____
____
____
____

CURRENT MEDICATIONS:

NAME	DOSE/HOW OFTEN	NAME	DOSE/HOW OFTEN

1.____ 5.______________________________________
2.____ 6.______________________________________
3.____ 7.______________________________________
4.____ 8.______________________________________

PAST MEDICAL HISTORY: *Have you ever had any of the following:*

___Heart Disease
___Arthritis
___Rheumatic Fever
___Anemia
___Tuberculosis
___Diabetes
___Heart Attack
___Glaucoma
___Asthma
___AIDS or HIV+
___Stroke
___Hepatitis
___Cancer
___Leukemia
___Mitral Valve Prolapse
___High Blood Pressure
___Drug Addiction
___Emphysema

REVIEW OF SYSTEMS: *Do you now or have you had within the past year any of the following:*

___Ear Infections
___Dizzy Spells
___Failing Vision
___Blurred Vision
___Nose Bleeds *Recurrent*
___Sinus Trouble
___Sore Throats *Frequent*
___Hoarseness *Prolonged*
___Hayfever/allergies
___Pneumonia/Pleurisy
___Bronchitis/Chronic Cough
___Asthma/Wheezing
___Shortness of Breath
___Chest Pain
___High Blood Pressure
___Heart Murmur
___Irregular Pulse/Palpitations
___Leg Pain – when walking
___Varicose veins/Phelbitis
___Loss of Apetite *Recent*
___Heartburn/Peptic Ulcer
___Persistent Nausea/Vomiting
___Sleeping or concentration difficulty
___Abdominal Pain *Chronic*
___Gall Bladder Trouble
___Jaundice/Hepatitis
___Diarrhea
___Constipation
___Diverticulosis
___Crohn's/Colitis
___Bloody Stools
___Hemorrhoids
___Hernia
___Overactive Bladder
___Urgency to Urinate
___Decrease in Force Flow
___Painful Urination
___Stress Incontinence – Urine leakage with exercise/movement
___Blood in Urine
___Kidney Stones
___Urine Infections *Frequent*
___Sexually Transmitted Diseases
___Weight Loss ___Gain
___Anemia
___Bruise Easily
___Blood Transfusions
___Cancer
___Diabetes
___Chronic Fatigue
___Thyroid Disease
___Seizures
___Stroke
___High Cholesterol
___Tremor/Hands Shaking
___Numbness/tingling sensation
___Headaches *Frequent*
___Arthritis/Rheumatism
___Back Pain *Recurrent*
___Bone Fracture/Joint Injury
___Osteoporosis
___Foot Pain
___Gout
___Rashes
___Psoriasis
___Eczema
___Depression
___Moodiness
___Suicidal Thoughts
___Mental Illness
___Rheumatic Fever
___Polio
___Measles

ALLERGIES:

Are you allergic to any medication? NO YES If yes, what medication?__________________________________

HABITS:

Do you drink alcoholic beverages? NO YES If yes, how many per day?______________
Do you smoke? NO YES If yes, how many per day?_________ How long have you smoked? ________________

FAMILY HISTORY (LIST ANY SERIOUS ILLNESSES OF FAMILY MEMBERS):

FAMILY MEMBER AGE (if alive)	AGE (if deceased)	CAUSE OF DEATH (SERIOUS)	ILLNESS (Heart, Diabetes, Cancer)
Father			
Mother			
Bro/Sis/Son/Daughter			
Bro/Sis/Son/Daughter			
Bro/Sis/Son/Daughter			

Has anyone in your family had an unusual reaction to anesthesia? NO YES

PAST SURGICAL HISTORY:

DATE	OPERATION	DATE	OPERATION
1.		5.	
2.		6.	
3.		7.	
4.		8.	

WOMEN ONLY:

Number of pregnancies / deliveries: __________ Did you breast feed? NO YES
Date of last mammogram:____________________ Do you take oral contraceptives? NO YES
IS THERE ANY POSSIBILITY OF YOU BEING PREGNANT AT THIS TIME? NO YES

I verify that the above information is true and accurate to the best of my knowledge.

____ _______________________________________

Patient Signature or Parent/Guardian if Patient is a Minor Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*This is an acknowledgement of receipt only.

I have received a copy of the Notice of Privacy Practices for Summit Plastic Surgery, LLC.

____
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

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1. Can we call you at home? ____Yes ____No
2. Can we leave a message for you at home? ____Yes ____No
3. Can we call you at work? ____Yes ____No
4. Can we leave a message for you at work? ____Yes ____No
5. With whom may we discuss your medical condition:
   1. ___________________________________ Relationship to you _________________
   2. ___________________________________ Relationship to you _________________