Health Information as of ()

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

Patient: **Email address:**		
Address: **Apt. #** **City** **State** **Zip Code**		
Phone: **Cell:**	**SSN:**	**DOB:**
What surgery are you considering? Breast Body Face Eyes Botox Laser Other: Reffered by: T.V. Radio Google Internet Friend: Other:		Height: Weight:
Have you ever been involved in any medical litigation? Emergency Contact: Phone: Relationship:		Occupation:

DO YOU NOW OR HAVE YOU EVER HAD…….. (You must circle an answer for each individual item)

Abdominal Bleeding	YES	NO	Glaucoma or Eye Problems	YES	NO
Abnormal Bleeding after Tooth Extraction	YES	NO	Goiter or Thyroid Disorders	YES	NO
Abnormal EKG	YES	NO	Glaucoma or Eye Problems	YES	NO
Airway Obstruction (Nasal)	YES	NO	Goiter or Thyroid Disorders	YES	NO
Alcoholism or Drug Dependency	YES	NO	Hay Fever	YES	NO
Arthritis	YES	NO	Heart Disease	YES	NO
Asthma	YES	NO	Heart Failure	YES	NO
Black Outs	YES	NO	Heart Murmur	YES	NO
Bleeding Tendency or Disorder	YES	NO	Hemorrhoids	YES	NO
Blood Pressure Abnormalities	YES	NO	Hepatitis	YES	NO
Blood Transfusion	YES	NO	High Blood Pressure / Hypertension	YES	NO
Breast Cancer	YES	NO	Hives	YES	NO
Bronchitis	YES	NO	Insomnia	YES	NO
Cancer	YES	NO	Kidney Disorder	YES	NO
Chest Pain	YES	NO	Kidney or Renal Disease	YES	NO
Chest Pain / Tightness	YES	NO	Kidney Stones	YES	NO
Cirrhosis of the Liver	YES	NO	Loose teeth	YES	NO
Colitis	YES	NO	Missed or irregular last menstrual period	YES	NO
Cosmetic bonding to teeth	YES	NO	Nervous Breakdown	YES	NO
Coughing or Spitting of Blood	YES	NO	Nervous Disorder	YES	NO
Dentures, Bridges, Capped Teeth or Crowns	YES	NO	Nipple Discharge (Apart from Normal Lactation)	YES	NO
Diabetes	YES	NO	Palsy or Paralysis	YES	NO
Digitalis Treatment	YES	NO	Piercing other than the Ears	YES	NO
Drug Habit	YES	NO	Pneumonia	YES	NO
Eczema	YES	NO	Positive Blood test for: HIV, AIDS, Hepatitis	YES	NO
Emphysema	YES	NO	Problem Constipation	YES	NO
Esophageal Varices	YES	NO	Psychiatric Hospitalizations or Care	YES	NO
Fracture of Neck or Spine	YES	NO	Rheumatic Fever	YES	NO
Frequent Indigestion	YES	NO	Seizures or Convulsions or Fainting Spells	YES	NO
Gallstones or Gallbladder Trouble	YES	NO	Self-Destructive Tendencies	YES	NO
Gastritis	YES	NO	Shortness of Breath	YES	NO

Skin Cancer	YES	NO
Skin Disease	YES	NO
Skin Disorders	YES	NO
Smokers Cough	YES	NO
Stroke	YES	NO
Tarry or Bloody Bowel Movements	YES	NO
Thyroid Disorder	YES	NO

Thyroid Problems	YES	NO
Tuberculosis	YES	NO
Ulcers	YES	NO
Visual Disturbances	YES	NO
Vomiting Blood	YES	NO
Xray Therapy	YES	NO
Yellow Jaundice	YES	NO

HAS ANYONE IN YOUR FAMILY EVER HAD….

History of Cancer	YES	NO
History of Heart Troubles	YES	NO
History of Strokes	YES	NO
Bleeding Problems	YES	NO
Anesthesia Problems	YES	NO

1. **Please list all present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, and weight loss drugs. **Include over-the-counter medications.**

_____

2. Do you have an allergic reaction to any medication? ❒ Yes ❒ No Which? _____

3. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?

❒ Yes ❒ No If yes, when and where? _____

4. Have you ever been on cortisone or steroid treatment? ❒ Yes ❒ No When? _____

5. Do you smoke? ❒ Yes ❒ No If so, how much? _____ For how long? _____

6. Are you pregnant? ❒ Yes ❒ No When was you last normal menstrual period? _____ h

8. Have you ever been under psychiatric care? ❒ Yes ❒ No When? _____Why? _____

9. Have you had any recent blood work done? ❒ Yes ❒ No Where? _____

10. Is there anything else you think the doctor should know? _____

_____

11. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons: (include where, when and why for each surgery)
SURGICAL OPERATIONS: _____
HOSPITALIZATIONS: _____

12. Have you been on any other cosmetic surgery consultations? If yes, with whom?

_____

Financial Agreement and Insurance Policy

I agree to pay to the order of Elite Plastic Surgery PLLC for services rendered at time of service. I understand that Dr. Moises Salama is an out of network provider and that the processing of insurance claims is a service and does not relieve me of my financial obligation. All insurance benefits paid to the patient are to be signed over to Elite Plastic Surgery PLLC. If your insurance company has not paid your account in full within 60 days, you will be responsible for charges. An outstanding balance after insurance benefits applied is the responsibility of the patient and must be paid in full. Designation of Authorized Representative- I hereby designate this medical provider to act as my representative during insurance or plan benefits appeal in the event of a coverage denial. I understand that this medical provider or practice has the right to decline or accept this designation at the time a denial is received. If this medical provider or practice accepts this designation, the outcome of any appeal is not guaranteed and I agree to pay all charges which remain unpaid by the insurance carrier or welfare benefit plan regardless of the outcome of any appeal. I authorize any holder of medical information about me to release to my insurance companies and their agents any information needed to determine these benefits payable for related services.

I understand the financial policy of Elite Plastic Surgery PLLC, and that I am financially responsible for all bills incurred. I have been informed and understand the refund policy of in that all deposits are nonrefundable and that refunds are not given for any service or treatment.

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Would you like for us to find out if you are approved for financing and interest free payments? □Yes No

Signature: _____ Date: _____