# DIGENIS PLASTIC SURGERY INSTITUTE 502-589-5544

Patient Information as of _____ (enter today's date)

(Please Print Legibly)

**Patient's Name** _____
First Middle Initial Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ **PREFERRED PHONE#** _____

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

Contact Restrictions: _____ **REFERRAL SOURCE:** _____

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

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

**Pharmacy phone number** _____

**Patient's Employer** _____ Occupation _____

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

**Emergency Contact** _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

**Primary Health Insurance Company** _____

Policy # _____ Group # _____ Ins. Phone _____

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

**Insured**: Name _____ DOB _____ Insured's SS: _____

**Secondary Health Insurance Company** _____

Policy # _____ Group # _____ Ins. Phone _____

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

**Insured**: Name _____ DOB _____ Insured's SS: _____

I understand that charges are payable on the day service is rendered, and that I am financially responsible for all charges incurred in this office. I authorize ***Digenis Plastic Surgery Institute, PLLC/Dr. Alexander G. Digenis*** to bill my insurance company directly, however, this does NOT transfer my financial obligation to my insurance company. I understand that this office will bill me should my insurance company deny reimbursement, or fail to pay. I acknowledge financial responsibility for fees not paid by this assignment and agree to pay any late fees, collection agency fees, and legal fees if my account becomes delinquent. I acknowledge that I was offered a HIPAA privacy policy for this office. I hereby grant permission for the use of my medical photos, for our office or website provided my personal information is not disclosed.

**Signature** _____ **Date** _____

# DIGENIS PLASTIC SURGERY INSTITUTE 502-589-5544

## Patient Medical History

Patient Name: _____Date:_____

If you are an existing patient, has anything changed since your last visit? □**NO** **or** □**YES**

*If yes, please answer the following:*

Height _____ Weight_____
Drug Allergies and Reactions: _____
Other Allergies (i.e. latex, iodine, tape, skin sensitivity):_____

**Present Medications (including diet pills, vitamins, & herbal preparations):**

| Medication | Times per Day | Milligrams | Reason Prescribed |
|---|---|---|---|
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**Previous Surgeries (please give year):**

| Surgery | Year |
|---|---|
| | |
| | |
| | |
| | |
| | |

Explain any reaction you have had to anesthesia: _____

List any diseases that run in your family (i.e. cancer, heart disease, diabetes, high blood pressure, blood clots):_____

Check any of the following conditions you have:

□Arthritis □HIV □Asthma
□Anemia □Hepatitis/Jaundice □Blood Clots
□Bleeding Disorders □High Blood Pressure □Lung Disease
□Kidney Disease □Heart Disease □Liver Disease
□Poor Circulation □Peptic Ulcers

Do you drink alcohol? □No □ Yes _____glass per week or month (circle)

Do you smoke? □No □Yes _____packs per day?

Do you take aspirin, ibuprofen, Motrin, Nuprin, Ecotrin, or Advil on a regular basis? □No □Yes
How Often?_____per day, week or month (circle) Reason _____