PATIENT REGISTRATION

(Confidential Information)

Date: ______________________

IDENTIFICATION INFORMATION			
PATIENT NAME Last First Middle Initial Male ___ Female ___			
If under 18 years of age, name of parent or guardian			If married, spouse's name
Home address (Including PO Box)		City	State Zip Code
Home Telephone Number	Cell	Best time to be reached	Email address
Birth date	Age	Occupation	Do you have children? Pls include ages

How did you hear about us? Please circle:

DEX online yellow pages Friend/Previous patient ________________________________

Direct Mail Fundraising event May we thank your referral? Yes ______ No ______

Internet: Breast implants 411 Implant Info.com(Nicole's site) Your Plastic Surgery Guide
Google Yahoo Other:____

Any special reason you chose our office? ____

____

Please check procedure(s) of interest:

Facial:
__Facelift
__Necklift
__Brow Lift
__Chin Implant
__Upper Eyelid Surgery
__Lower Eyelid Surgery
__Botox
__Lip Augmentation
__ Fillers (Restylane/Juvederm)
__Nasal Surgery
__Otoplasty
__Laser Resurfacing

Liposuction:
__Abdomen
__Flanks
__Hips
__Inner Thighs
__Outer Thighs
__Full Thighs
__Knees
__Arms
__Neck
__Upper Back
__Lower Back
__Chest

Body:
__Breast Augmentation
__Breast Lift
__Peri-aerolar Mastopexy/Augmentation
__Breast Reduction
__Tummy Tuck
__Lower Body Lift
__Arm Lift

Skin Care:
__TCA Peel
__Glycolic Peel
__Microlaser Peel
__Thermage
__Microdermabrasion

Other: ____

____

Have you had any previous cosmetic surgery? ____

____

What would you like to achieve through having cosmetic surgery? _____________________________

____

Do you have any specific questions or concerns? ____

How does your spouse or significant other feel about cosmetic surgery? ________________________

When do you anticipate having the procedure? ____

MEDICAL HISTORY

NAME: ______________________________ HEIGHT: ____________ WEIGHT: ___________

ARE YOU ALLERGIC TO ANY MEDICATION YES/NO
IF YES, WHICH MEDICATION(S)?
____

TYPE OF REACTION? ____

GENERAL ANESTHESIA/PREVIOUS SURGERY (Please list)

Operation | Date | Location (Hospital/Drs. Office)
____

____

PLEASE CHECK ALL THAT APPLY:

__Hypertension/High Blood Pressure
__Angina or Chest Pain
__Heart Attack
__Heart Disease
__Asthma
__Ulcer Disease
__Hepatitis/Jaundice
__Stroke
__Family history clotting disorder
__Dentures
__Sleep Apnea
__Allergy to adhesive tape
__Wound healing problems
__Large scars or keloids
__Sensitive Skin
__Aids Virus (HIV)
__Lung Disease
__Bleeding Problems
__Thyroid Problems
__Epilepsy/Seizures
__Blood transfusion
__Leukemia
__Cancer Surgery
__Chemotherapy
__Radiation therapy
__Diet Therapy
__Recreational Drug use
__Emotional or Psychiatric Problems
__Family History of Breast Cancer
__Latex Allergy/sensitivity

__Other: ____

MEDICATION, DRUGS

Please list all medications you are now taking including birth control pills, diuretics (water pills), blood pressure or heart medications, tranquilizers, hormones, blood thinners, aspirin, motrin, etc.

NAME OF MEDICATION	DOSAGE

What is your approximate DAILY consumption of the following:

Aspirin ____________ Tobacco ____________ Coffee/Tea ____________ Alcohol ____________

- I understand hereby affirm that the information given above is accurate and complete to the best of my knowledge.
- I hereby authorize Braden C. Stridde, M.D. to release medical information accumulated in the course of my examination and /or treatment to any other doctor , hospital, nursing home or insurance company. I authorize the release of medical information contained in any doctors or hospital records to Dr. Stridde. I hereby agree to full responsibility for all expenses incurred by or on the account of the above named patient. For insurance covered procedures, I authorize my Insurance Company to pay Dr. Stridde directly for all services rendered. I am financially responsible for any existing balances left from the payment.
- In the event that an employee should receive a needle stick during your treatment a sample of your blood will be drawn and tested for HIV, Hepatitis B and C. This is done in the strictest confidence and the results will not be released to anyone without your written permission. There will be no charge to you for these tests.
- I understand that photographs may be taken as part of my medical record. They will be used to aid in my care, or for education purposes, These will remain confidential, unless you give us written permission to use your photos.

SIGNATURE: ______________________________ DATE: ____________________

SIGNATURE: ______________________________ Relationship: __________ DATE: ____________