Scottsdale Plastic Surgeons, PLC
15757 North 78th Street, Suite A
Scottsdale, AZ 85260
(480) 787-5815
www.ScottsdalePS.com

PATIENT INFORMATION FORM

Patient Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Carrier: _____

DOB: _____ Age: _____ Gender: _____

Social Security Number: _____ Email Address: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

How did you hear about our clinic?

☐ ScottsdalePS.com ☐ Patient Referral: _____ ☐ Insurance Referral: _____
☐ Facebook ☐ Friend: _____ ☐ Dr. Referral: _____
☐ Google ☐ Salon: _____ ☐ Seminar: _____
☐ Other: _____

What is the nature of your visit? _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Insurance

Name: _____ Policy #: _____ Group ID: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance

Name: _____ Policy #: _____ Group ID: _____

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Assignment and Release

I, J J, have insurance coverage and assign to Scotsdale Plastic Surgeons all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured / Guardian Date

Section I: Surgery and Anesthesia History

1. Have you ever had surgery? ☐ No ☐ Yes, please describe:

_____

_____

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

_____

_____

Section II: Specific Medical History

1. Are you pregnant? ☐ No ☐ Yes Height: _____ Weight: _____

	Have you or do you still have:	No	Yes	Description
2.	Asthma	☐	☐	
3.	Emphysema	☐	☐	
4.	High Blood Pressure	☐	☐	
5.	Heart Trouble	☐	☐	
6.	Hepatitis or Liver Trouble	☐	☐	
7.	Kidney Trouble	☐	☐	
8.	Diabetes	☐	☐	
9.	Epilepsy or Seizures	☐	☐	
10.	Stroke	☐	☐	
11.	Problem Scarring	☐	☐	
12.	Have you been advised to or had psychiatric care?	☐	☐	

13. Others Not Listed: _____

Section III: Social History

1. Do you smoke? ☐ No ☐ Yes, how much? _____
2. Do you drink? ☐ No ☐ Yes, how much? _____

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3. Do you have children? ☐ No ☐ Yes, how many? _____

Section IV: Family History

	Have any blood relatives had any of the following?	No	Yes	Description
1.	Cancer	☐	☐	
2.	Bleeding Tendency	☐	☐	
3.	Leukemia	☐	☐	
4.	Heart Disease	☐	☐	
5.	High Blood Pressure	☐	☐	
6.	Repeated Infections	☐	☐	
7.	Chronic Lung Disease	☐	☐	
8.	Tuberculosis	☐	☐	
9.	Asthma	☐	☐	
10.	Severe Allergies	☐	☐	
11.	Kidney Disease	☐	☐	
12.	Arthritis	☐	☐	
13.	Mental Illness	☐	☐	
14.	Convulsions or Fits	☐	☐	
15.	Migraine Headaches	☐	☐	
16.	Diabetes	☐	☐	
17.	Gout	☐	☐	
18.	Thyroid Trouble	☐	☐	
19.	Obesity	☐	☐	

Section V: Medications

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list:

_____

_____

Section VI: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

_____

_____

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

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Consent to Communicate

Patient Name:

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appt Reminders				
☐ Email Medical Info				
☐ Email Marketing Info				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Page	-	-	☐	-
☐ Text Appt Reminders – if so, list cell carrier:				
☐ Text Marketing Info – if so, list cell carrier:				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____