USA PLASTIC SURGERY

STEVEN J. WHITE M.D.

Name:____ Age:_______
First Middle Last

Name you like to be called: ___________________________Sex: ___________ Marital Status: ______________________

Date of Birth: _______________ Social Security No.: _____________________ Driver's License: ___________________

Address: ____
Street Apt. No. City State Zip

Home Phone: _____________________ Mobile : ________________ Employer's Phone: __________________

E-Mail Address: ____

Employer: ____
Name Address
____ Occupation: _______________________
City State Zip

Spouse's Name: ____ Social Security No.: ___________________________

Employer: ____ Occupation: ___________________________________

E-Mail Address: ____

Whom may we thank for referring you? ____

What is your area of concern? ____

Emergency Contact: ________________________________ Relationship: _______________ Phone: _________________

Primary Insurance:_________________________________ Address: _____________________________________
Street City State Zip
Phone: _____________________ Insured: ________________________ Relationship: ______________________________
ID No.: __________________________________ Group No.: _________________ Insured DOB: __________________

Secondary Insurance: ______________________________ Address: _____________________________________
Street City State Zip
Phone: _____________________ Insured: ________________________ Relationship: ______________________________
ID No.: __________________________________ Group No.: ________________ Insured DOB: ___________________

When did you first consult with the doctor? ____

Was this an accident? _____________ If so, did it happen on the job? ________________ Date of accident: ____________

Name of referring physician: ____

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance and other health plans to Dr. White. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signature: ____ Date: _______________________________________

I hereby give my permission to have the appropriate photographs taken for the purpose of completing my records.

Signature: ____ Date: _______________________________________

USA PLASTIC SURGERY
STEVEN J. WHITE M.D.

Name: ____ Height: ______________Weight: _______________

ALLERGIES (Medications, creams, adhesive tape, ointments, etc.) Please List: ____________________________

____

Current Medications: ____

Current Medical conditions: ____

Past Hospitalization or Surgery (Please include date and type of anesthesia): _________________________________

____

Problems with anesthesia ? (Local or General): ____

Problems with bleeding after surgery? ____

Have you ever had ?	**Yes**	**No**		**Yes**	**No**
Alcohol/Drug Abuse	Y	N	GERD/Reflux or Heartburn	Y	N
Allergies	Y	N	GI Upset/Irritable Bowel (IBS)	Y	N
Anemia	Y	N	Glaucoma	Y	N
Angina	Y	N	Gynecological Issues	Y	N
Anxiety	Y	N	Heart Attack	Y	N
Arthritis	Y	N	Hepatitis Type (A, B, C)________	Y	N
Asthma	Y	N	High Blood Pressure	Y	N
Bell’s Palsy	Y	N	High Cholesterol	Y	N
Bladder/Kidney Problems	Y	N	HIV/AIDS	Y	N
Bleeding Problems	Y	N	Kidney Disease/Failure	Y	N
Blood Clot	Y	N	Liver Disease/Jaundice	Y	N
Blood Transfusion	Y	N	Migraine Headaches	Y	N
Breast Lump/Problems	Y	N	PE/ Pulmonary Embolism	Y	N
Cancer (list type: _____________)	Y	N	Prostate Problems	Y	N
Cold sores/Fever Blisters	Y	N			
Depression	Y	N	Seizure/Epilepsy	Y	N
Diabetes	Y	N	Skin Conditions _____________	Y	N
DVT/Deep Venous Thrombosis	Y	N	Sleep Apnea	Y	N
Emphysema/COPD	Y	N	Stomach Problems/Peptic Ulcers	Y	N
Facial Nerve Damage	Y	N	Stroke	Y	N
Gallbladder Problems	Y	N	Thyroid: Hyper (high)/ Hypo (low)	Y	N

Other Medical Condition? ____

Do you have vision in both eyes ? Y N

Do you wear glasses / contacts ?_______________

Condition of teeth: Dentures / caps / implants

____

Do you smoke ?________________ For how long ?__________________ No. of Packs a day ? ____________

Do you drink alcohol ? __________ How often ? ____________________ No. of drinks ?_________________

Do you, or have you ever used drugs for recreational purposes ?__________ Marijuana ?__________________

Cocaine/Crack ? ___________ Heroin ?_____________ Other ?_________ Last Time? ___________________

Have you ever received counseling or treatment for a mental condition, emotional problem or depression ?____

If yes, please describe: ____

Are you currently under the care of a physician ?_______ Physician’s Name: ___________________________

Problem being treated ?____

Primary care physician: ____

Name **Address**