

MATTHEW H. CONRAD, M.D.
COSMETIC & RECONSTRUCTIVE PLASTIC SURGERY

PATIENT INFORMATION PLEASE PRINT ALL INFORMATION CLEARLY

Last Name: _____ First Name: _____ MI _____

Date of Birth _____ Age _____ Sex _____ SS# _____ Home Phone () _____

Work Phone () _____ Cell Phone () _____ Address _____

City _____ State _____ Zip Code _____ E MAIL ADDRESS _____

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Race _____

Patient's Employer _____

IF PATIENT IS A CHILD:

Mother's Name: _____ SS# _____ Date of Birth: _____

Father's Name: _____ SS# _____ Date of Birth: _____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY (Other than Parent)

Name _____ Relationship to patient _____ Phone () _____

REFERRING PHYSICIAN

PRIMARY CARE PHYSICIAN

Name _____ Phone () _____ Name _____ Phone () _____

INSURANCE INFORMATION: THIS INFORMATION IS NECESSARY, PLEASE COMPLETE

PRIMARY INSURANCE INFORMATION

SECONDARY INSURANCE INFORMATION

Insurance Company _____

Insurance Company _____

Subscriber _____

Subscriber _____

Subscriber's Date of Birth _____

Subscriber's Date of Birth _____

Subscriber's SS# _____

Subscriber's SS# _____

Subscriber's Relationship to Patient _____

Subscriber's Relationship to Patient _____

Group # _____ Policy/ID # _____

Group # _____ Policy/ID # _____

Subscriber's Employer _____

Subscriber's Employer _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS. I REQUEST PAYMENT OF AUTHORIZED BENEFITS BE MADE TO **MATTHEW H. CONRAD MD**, ON MY BEHALF FOR SERVICES FURNISHED ME. THIS WOULD INCLUDE MEDICARE, MEDICAID AND CHAMPUS TO BE ASSIGNED. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE COMPANY AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS FOR RELATED SERVICES.

SIGNATURE _____ **DATE** _____

MEDICAL HISTORY

PLEASE ANSWER **ALL** QUESTIONS

Patient's Name: _____

How did you hear about our office/ referred by _____ Age: _____

What is your reason for today's consultation? What would like to discuss with Dr. Conrad today during your visit?

ALLERGIES

Penicillin (Y) (N) Effect _____

Novocain/Xylocaine (Y) (N) Effect _____

Latex (Y) (N) Effect _____

List any other drug or other allergies? _____

ALL MEDICINES YOU ARE TAKING: (INCLUDING ALL HERBALS)

Asprin () _____ Ibuprofen () _____ Aleve () _____ Advil Products () _____

Vitamins () _____

Vitamin E () _____ Diet pills () _____ Midol Products () _____ Sinutab () _____

Over the counter: _____

Herbals () _____ (ex: St. Johns Wort, Ginger, Ginco, Ginseng, Camomille) _____

Fish Oil () _____ Flax Seed oil () _____ Blood thinner () _____

MEDICAL PROBLEMS YOU HAVE OR HAVE HAD:

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

(Please check all that apply)

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Cold Sores/Oral Herpes	()	()	Bleed Easily	()	()
Skin rashes	()	()	Heart Condition	()	()
Blurred Vision	()	()	Heart Murmur	()	()
Wear contacts	()	()	Stomach Ulcer	()	()
Ear Trouble	()	()	Bowel Problems	()	()
Deafness	()	()	Constipation	()	()
Dizzy Spells	()	()	Sinus Trouble	()	()
Nose Bleeds	()	()	Diabetes	()	()
Nose Obstruction	()	()	Headaches	()	()
Swelling of the Neck	()	()	Stroke	()	()
Asthma	()	()	Paralysis	()	()
Shortness of Breath	()	()	Convulsions/Seizures	()	()
Bronchitis	()	()	Depression	()	()
Emphysema	()	()	Arthritis	()	()
Pneumonia	()	()	Back Pain	()	()
Tuberculosis	()	()	Fevers	()	()
Chest Pain	()	()	Bleed/Bruise Easily	()	()
High Blood Pressure	()	()	Bleeding Disorder	()	()
Heart Attack	()	()	Anemia	()	()
Ankles Swell	()	()	Cancer	()	()
HIV Positive	()	()	Breast: Nipple Discharge	()	()
			Lumps or Recent Changes in either	()	()

FOR FEMALES ONLY:

Birth Control Pills () ()
Fibrocystic Disease () ()
Menstrual Problems () ()

How many pregnancies: _____ How many living births: _____ How many miscarriages: _____
Do you ever do monthly self-breast exam _____ Y _____ N
Have you ever had a mammogram? _____ Y _____ N if so, was it normal _____
When and where was it done? _____

SURGICAL HISTORY

List all previous hospitalizations, operations, or serious injuries:

<u>Year</u>	<u>Reason for hospitalization or operation</u>	<u>Hospital/Location</u>

SOCIAL HISTORY

Do you smoke? _____ Y _____ N If yes, how many packs per day _____ per year _____
If you recently quit when was your last cigarette? _____
Do you drink alcohol? _____ Y _____ N If yes, _____ socially or binge on weekends _____
Do you drink coffee? _____ Y _____ N How many cups per day _____
Who do you live with? _____
What is your occupation? _____
Do you lift more than 20 lbs on a routine basis (@ home or work?) _____ Y _____ N

FAMILY HISTORY

Breast Cancer _____ Y _____ N
Ovarian Cancer _____ Y _____ N
Colon Cancer _____ Y _____ N
Are there any other medical problems that we should be aware of?

Patient and/or Guardian Signature _____ **Date** _____

Physician's Signature _____ Date _____

Physical Exam:

Height: _____ Weight: _____ B/P _____ Pulse _____

Current Bra Size: _____ Desired Bra Size: _____

HEENT:

Cor:

Chest:

Abdomen: _____ S,NT,ND _____ No masses, organomegaly Hernias? _____ Y _____ N

Scars? _____ Y _____ N Breasts: _____ No masses, LAD,NAC,D/C except:

Extremities: _____ No C/C/E

AGREEMENT TO GUARANTEE PAYMENT/ASSIGN BENEFITS/RELEASE INFORMATION

The undersigned agrees, whether as agent or patient, to accept full responsibility for all charges for services ordered on behalf of the patient and by the physician attending the patient, and agrees to pay all charges at time of service or upon receipt of statement. I understand that I am responsible for any costs incurred in the reasonable attorney fees and/or court costs. This agreement is valid for the services provided on this date and for all future visits and services until revoked by me.

I authorize third parties to pay directly to the physician insurance benefits due for services rendered on behalf of the patient.

I authorize the physician to furnish my insurance company and/or other responsible third party pay or their representatives any medical information necessary to process this claim.

PATIENT and/or GUARDIAN

DATE

AGREEMENT TO GUARANTEE PAYMENT FOR OUT OF NETWORK/UNAUTHORIZED COVERAGE

I understand that the services I am requesting to be rendered by Matthew H. Conrad, MD may be out of network or unauthorized by insurance (HMO/PPO/PPC/POS/Indemnity/Auto Insurance/Worker’s Compensation/Medipass/Coventry, etc.). I understand that if Dr. Conrad is out of network, I will be held responsible for all charges. I also understand if I am receiving services from an out-of-network provider, any payment(s) made on the part of insurance company may and or will be made directly to me. I, in turn, agree to sign over the payments to Matthew H. Conrad, MD.

PATIENT and/or GUARDIAN

DATE

CONSENT FOR PHOTOGRAPHY

I hereby authorize Matthew H. Conrad, MD and his associates to take photographs, slides, and/or videotapes appropriate for my surgery. In addition, I authorize Matthew H. Conrad, MD and his associates to take photographs, slides, and/or videotapes of my consultation concerning my surgery.

I further authorize Matthew H. Conrad, MD to use the photographs, slides and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing the photos, slides, and/or videotapes on public or commercial television, and all other electronic media, or using the photographs, slides and/or videotapes for purposes of medical publication, lay publication, medical education, patient education or during lectures to medical or lay groups.

I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of the photographs, slides, and/or videotapes of my surgery and/or the consultation concerning that surgery.

I hereby grant permission for the use of any of my medical records, illustrations, photographs, or other imaging records created in my case, for use in examination, testing, credentialing, and/or certifying purposes by the American Board of Plastic Surgery, Inc. The Board requires that all-identifiable characteristic, with the exception of a full-face photograph or photograph of uniquely identifiable characteristics, be blanked out for submission of materials for the Oral Examination of the American Board of Plastic Surgery to protect patient privacy.

_____ Initial here if you do not wish for Dr. Conrad to use your photos for the above mentioned purposes.

PATIENT and/or GUARDIAN

DATE

WITNESS

DATE