Legacy Plastic Surgery and Aesthetics

Patient Information

First Name: ____________________________ Last Name: _______________________ MI:_____

Today's Date__________ Date of Birth: ______________ Age:________________ Sex: M / F

Circle Ethnicity (for insurance data purposes) Hispanic/Latino Non-Hispanic/Latino

Marital Status:_________________ Occupation:____________________________

Street Address: ____

City, State, Zip: ____

Home Phone: ______________________________ Cell Phone: __________________________

Email Address: ____

How would you like to receive reminders for appointments? Email Text Both

Would you like to receive monthly emails with our office specials? Yes No

How Did You Hear About Legacy Plastic Surgery and Aesthetics? PLEASE CHECK ONE:

- ☐ Physician Referral; Name: ____
- ☐ Client Referral; Name: ____
- ☐ Internet/Social Media; Explain: ____
- ☐ Other Explain: ____

Emergency Contact

First Name: __________________________ Last Name:__________________________________

Phone: ____

Relationship: _______________________________________

Primary Care Physician:
Name: __________________________________ Phone: ________________________________

Briefly describe your treatment interest:____

____

____

Patient Medical History - Check all that apply

- [ ] Anemia
- [ ] Arthritis
- [ ] Asthma
- [ ] Bleeding Disorder
- [ ] Blood Clots
- [ ] Breast Cancer
- [ ] COPD
- [ ] Depression
- [ ] Diabetes
- [ ] Glaucoma
- [ ] Gout
- [ ] Heart Attack/Disease
- [ ] Hepatitis
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] HIV/AIDS
- [ ] Hives
- [ ] Keloid
- [ ] Kidney Stones
- [ ] Lung Disease
- [ ] Other ____________
- [ ] Psychiatric Disorders
- [ ] Reflux Disease
- [ ] Seizures
- [ ] Skin Cancer
- [ ] Skin Issues (eczema etc)
- [ ] Stroke
- [ ] Thyroid Disorders
- [ ] No Pertinent Medical History

List past surgeries/hospitalizations and dates - if none write none

____

____

Dominant Hand: Left Right Ambidextrous

Current Symptoms - Check all that apply

- [ ] Fever / Chills
- [ ] Nausea/Vomiting
- [ ] Swollen Lymph nodes
- [ ] Chest Pains
- [ ] Cough
- [ ] Difficulty Breathing
- [ ] Blurred Vision
- [ ] Headache
- [ ] Breast Lump
- [ ] Numbness
- [ ] Joint Pain / limited motion
- [ ] Weakness
- [ ] Weight Loss

Have you ever used Accutane?	_____Yes	_____No
Have you ever used Renova, Retin-A, Tazorac, Avita?	_____Yes	_____No
Have you ever used glycolic, lactic or salicylic acid products?	_____Yes	_____No

Family History (do not include self)	Check all that apply	Family member with condition
Abnormal Bleeding		
Abnormal Clotting		
Adopted		
Anesthesia Problems		
Autoimmune Disorder		
Brain Tumor		
Breast Cancer		
Cleft Lip or Palate		
Dementia		
Depression		
Diabetes		
Drug Allergies		
Endocrine Disease		
Hearing Loss		
Heart Disease		
Hemophilia		
High Blood Pressure		
Kidney Disease		
Liver Disease		
Lung Cancer		
Malignant Hyperthermia		
Skin Cancer		
Skin Disease		
Substance Abuse		
Von Willebrand		
Other Cancer		
Other Condition		
No Pertinent Medical History		

Allergies:

____

____

____

Current Meds and Dosage:

____

____

____

Pharmacy Name and City:

____

Social History: check one that applies

Alcohol

☐ No Alcohol Use

☐ Alcohol Use Socially

☐ Alcohol Use Daily

☐ History of Alcoholism

Illegal Drugs:

☐ No Illegal Drug Use

☐ Illegal Drug Use Socially

☐ Illegal Drug Use Daily

☐ History of Illegal Drug Abuse

Smoking Status:

☐ Never Smoked

☐ Former Smoker

Start: ________ End:_______

☐ Current Use Everyday

☐ Use Some Days

Height (inches): _____________

Weight (lbs): ________________

Medical History Verification

All information provided is accurate and complete to the best of my knowledge.
Patient Initials: __________ Parent or Guardian Initials: __________ Date: ___________

AUTHORIZATION OF RELEASE OF INFORMATION
I hereby authorize the physician to release information requested by my insurance company or Workman's compensation carrier. I also authorize my physician to release information to any hospital or physician I may be referred to or referred from.
Patient Initials: __________ Parent or Guardian Initials: __________ Date: ___________

ASSIGNMENT OF BENEFITS
I hereby authorize assignment and payment directly to my physician major benefits due to me.
Patient Initials: __________ Parent or Guardian Initials: __________ Date: ___________

PRIVACY NOTICE
I acknowledge that I have received a copy of Legacy Plastic Surgery's privacy notice.
Patient Initials: __________ Parent or Guardian Initials: __________ Date: ___________

Office Policies

We have a 24 hour cancellation policy.

- Any appointment cancelled with less than 24 hours notice will incur a $30 cancellation fee. If you need to leave a voicemail to cancel your appointment, that is acceptable provided the message has been left with 24 hours advanced notice.
- No-shows will also incur a $30 charge.
- This fee may be assessed at your next visit.

All prepaid packages will expire 1 year from the purchase date.

Packages are not transferable between multiple patients.

- Family members cannot share packages.

All product sales are final.

- Any product that has been opened cannot be returned or exchanged for any reason.

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history as a current medical history is essential for the caregiver to execute appropriate treatment procedures. I have reviewed and understand the office policies.

Signature: ____Date: _________________________