SIWY PLASTIC SURGERY

Barbara K. Siwy, M.D.

Date _____

Name _____ Date of Birth _____

Last complete medical checkup date: _____ Are you in good health? ☐ Yes ☐ No *(If no, explain)*

_____

Do you smoke? ☐ Yes ☐ No If so, how much? _____

Have you ever been a regular smoker? ☐ Yes ☐ No When did you stop smoking? _____

Drugs or medications you are allergic to: _____

Drugs or medications you are presently taking: _____

Do you have a pacemaker/defibrillator/CPAP machine/inhaler? _____

Previous cosmetic surgery and year: _____

Previous major illnesses, surgeries or injuries: _____

Have you ever had any of the following? If yes, please check.

- ☐ Heart disease
- ☐ High blood pressure
- ☐ Sugar diabetes
- ☐ Asthma/lung problems
- ☐ Phlebitis/blood clots
- ☐ Tested positive for TB
- ☐ Hepatitis or liver problem
- ☐ Bleeding/bruising problems
- ☐ Cancer
- ☐ Epilepsy
- ☐ Kidney disease

How much regular exercise do you do? _____

Height: _____ Weight: _____

Reason for today's visit: _____

Have you consulted another doctor about this? _____

PLEASE TURN OVER TO COMPLETE FURTHER INFORMATION

Have you ever had a bad reaction to general anesthesia, gas, pentothal, etc.? ☐ Yes ☐ No

Has any blood relative ever had a bad reaction to an anesthetic? ☐ Yes ☐ No

Have you required unusually large amount of local anesthetic for medical or dental procedures? ☐ Yes ☐ No

Have you ever had a bad reaction to local anesthetic? (Novocain, etc.) ☐ Yes ☐ No

Are you allergic to adhesive tape? ☐ Yes ☐ No

Do you bleed unusually easily from cuts, surgery, tooth extractions, etc.? ☐ Yes ☐ No

Are you a slow or poor healer? ☐ Yes ☐ No

Do you form large scars or keloids? ☐ Yes ☐ No

Do you have any skin diseases, hives, eczema, rashes or have you had cold sores? ☐ Yes ☐ No

Do you have frequent infections or boils? ☐ Yes ☐ No

Are you currently taking steroid medication? ☐ Yes ☐ No

Do you have shortness of breath or chest pains while walking? ☐ Yes ☐ No

Do you have or have you had any significant emotional problems? ☐ Yes ☐ No

Have you ever been advised to see a counselor or therapist? ☐ Yes ☐ No

Have you ever had a history of facial pain, TMJ (Temporomandibular Joint Pain) or frequent headaches? ☐ Yes ☐ No

If you are considering breast surgery, have you had a recent mammogram? ☐ Yes ☐ No

(If so, when and where?)

Do you have a family history of breast cancer? ☐ Yes ☐ No

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN FURTHER:

PLEASE TURN OVER TO COMPLETE FURTHER INFORMATION

ALL PATIENTS

I authorize release of my medical records to Dr. Barbara K. Siwy. This authorization is valid unless revoked by me in writing.

Signature: _____ Date: _____

Printed name: _____
Include maiden name if applicable

I consent to be photographed before, during and after treatment. These photographs shall be the property of Dr. Barbara K. Siwy and may be published in scientific journals and/or shown for scientific reasons.

Signature: _____ Date: _____

Relationship to patient: _____

INSURANCE PATIENTS

I hereby authorize Dr. Barbara K. Siwy to release information requested to my insurance company or Worker's Compensation carrier. I also authorize Dr. Siwy to release information to any hospital or physician that I may be referred to by this office.

Signature: _____ Date: _____

Relationship to patient: _____

I request that payment of authorized insurance benefits and/or Medicare be made to Dr. Siwy or my behalf for any services furnished to me by Dr. Siwy, including my physician services. I authorize any holder of medical or other information about me be released to HCFA and/or the insurance company and its agents or information needed to determine these benefits or any benefits for related services.

I hereby agree to pay Dr. Barbara K. Siwy the charges for all medical services rendered. I shall also be responsible for any attorney fees required to collect for these services, court costs and collection agency fees, to which may be added prejudgement and/or post-judgment interest at the then current legal rate.

Signature: _____ Date: _____

Relationship to patient: _____

COSMETIC PATIENTS

I hereby agree to pay Dr. Barbara K. Siwy the charges for all medical services rendered. I shall also be responsible for any attorney fees required to collect for these services, court costs and collection agency fees, to which may be added prejudgement and/or post-judgment interest at the then current legal rate.

Signature: _____ Date: _____

Relationship to patient: _____

We request fees for office services and visits at the time service is rendered.