

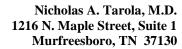


Last Name		First		_MI		
Mailing Address (Street Nan	ne)					
City						_
Date of Birth:	Age: Sex:	MF S.S. #	E	_ Height'	" Weight	_lb
Marital Status SM	_DW Spouse	Name:				
Telephone: Home		Cell		Work		
May we leave information or	n your answering machir	ne or voice mail?	YN	May we call yo	ou at work?Y	N
Email address:			May	we contact you by	email? Y I	N
How did you hear about our						_
Your Occupation:						_
Employer Address:						_
Emergency Contact Person_			Relat	tionship		_
Telephone						_
Primary Care Physician						_
Address of Physician		City			7:	_
Referring Physician(if other than PCP above)	First Last	•		Fax:	Zip	
(ii other than I et above)	Thist Last					_
Name of Primary Insurance_		Insur	ance Address			
Policy Holder's Name	DOE	3	Policy#	Group#		
Secondary Insurance		Insurance Address				
Policy Holder's Name	DOE	3	Policy#	Group#		

I hereby authorize you to release any information, including the diagnosis and record of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay benefits otherwise payable to me directly to Tarola Plastic Surgery, PLLC. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependent.



Name	neDate of Birth					
Please list your reasons for this consultation						
Is this auto or work related?YI	N If yes, date of accident					
PAST MEDICAL HISTORY Have you ever had or been treated for any o	f the following: (Please check all that app	oly)				
•	_Peptic/stomach ulcer _Bladder infection _Difficulty in sleeping _Changes in bowel habit/bleeding _Thyroid problem _Liver disease/jaundice/hepatitis _Asthma/wheezing t any other medical history	_Severe ear, nose, throat trouble _Neuritis _Head injury _Mitral valve prolapse _Indigestion/GERD/reflux _Excessive tiredness/fatigue _Pacemaker/AICD _Chills/fever/night sweats _Chest pain/pressure _Gout _Skin rash/disease _Kidney stone/blood in urine _Anemia _Bleeding disorder/blood/clot/DVT _Aids/ARC _Epilepsy/seizure disorder				
Have you ever consulted or been treated by If yes, please explain circumstances						
Women: Are you, or might you possibly be Number of Term Pregnancies	pregnant?YES NO Tak Number of Children					
PAST SURGICAL HISTORY Please list all prior surgeries, including cosm	netic surgeries.					
Were there any complications? Y						
Have you or a family member had any problem. If yes, please explain circumstances:						
MEDICATIONS Do you take blood thinners, aspirin or non- If yes, please list:	steroidal anti-inflammatories (NSAIDs)?					





Are you allergic	to latex? Y	N
		ns?YN If yes, please list:
1.	nedication, please	ntly taking including strength and how often:
Do you live alone Are you currently	Single ed Y N e? Y N y under treatmen	Married Divorced Widow If yes, what is your occupation? t for alcohol or drug abuse?YES NO ne in one week? None Light Moderate Heavy Quit date
Do you presently Have you ever sn	smoke? YE noked? YE	S NO If yes, how many packs per day? How long?
	Alive	List illnessesList cause of death
Father		List illnesses List cause of death
Sister	Alive Deceased	List illnesses List cause of death
Brother	Alive Deceased	List illnesses List cause of death
I attest that the above	e information is comp	lete and accurate.
Patient Signature	/Guardian Signa	ture (if under 18) Date