

PLASTIC & RECONSTRUCTIVE SURGERY OF SUMTER, P.A.

Patient Information

Today's Date: _____ Referred to our office by _____

Reason for today's visit: _____

Name _____ Birthdate _____ Age _____
Last First MI Month Day Year

Mailing Address _____ Main Phone (____) _____

City _____ State _____ Zip _____ Cell Phone (____) _____

Marital Status: M ___ S ___ Sep ___ Wid ___ Div ___ Race _____ Sex Male ___ Female ___

Social Security # _____ E-Mail _____

Employer _____ Work Phone (____) _____

Address _____

Spouse/Guardian Information

Name _____ Birthdate _____ Age _____
Last First MI Month Day Year

Main Phone (____) _____ Relationship to Patient: _____

Social Security # _____ E-Mail _____

Employer _____ Work Phone (____) _____

Address _____

Medical Information

Height _____ Weight _____ Family Physician Name _____

Do you smoke/Vape? _____ Have you or are you currently being treated for any of the following?

Heart Problems: _____ Blood Pressure: _____ Lung Problems: _____ Bleeding Disorders: _____

Allergies to Medications (please list): _____

List All Medications currently being taken _____

(If you need additional space please ask for separate form)

Are you taking aspirin? _____ Are you pregnant? _____ Are You on Steroids? _____

UP TO DATE: _____

Accident/Injury Information (Leave blank if does not apply)

Today's Date: _____ Referred to our office by _____

Date of Injury: _____ Result of: Auto Accident: _____ Work Related: _____

What injury did you sustain? Please Describe: _____

Emergency Information

Please provide us with the name, address and telephone number of a friend or relative that we may contact in case of an emergency:

Name _____ Phone (____) _____

Address: _____

Acknowledgment of Responsibility

I have completed this form fully and completely, and certify that I am the duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though there is some type of insurance coverage, I am responsible for payment of services. I authorize the release of information to my insurance company and request that payments be made directly to Plastic & Reconstructive Surgery of Sumter, P.A.

Signature of Authorized Person

Consent to Take Photographs - For Medical Documentation and Insurance Only

Plastic & Reconstructive Surgery of Sumter, P.A. requires that photographs be taken of patients for medical documentation. These photographs are used, if necessary, to submit to your insurance company for approval of surgical procedures. When these photographs are taken we will keep them confidential as reasonably as possible.

I authorize Plastic & Reconstructive Surgery of Sumter, P.A. to take photographs of me before, during, and after office procedure, surgery or clinic visit.

I permit these photographs to be submitted to my insurance company if necessary for authorization for surgery.

Signature of Authorized Person