

Olympic Plastic Surgery Center
PATIENT INFORMATION

PATIENT NAME _____ AGE _____
(First) (Middle) (Last)

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (____) _____ CELL PHONE (____) _____ WORK PHONE (____) _____

IF UNABLE TO REACH ME AT ABOVE NUMBER'S, A MESSAGE MAY BE LEFT AT (____) _____

Email address _____

EMPLOYED [] RETIRED [] HOMEMAKER [] STUDENT [] UNEMPLOYED []

EMPLOYER: _____ OCCUPATION: _____

DATE OF BIRTH _____ SOCIAL SECURITY# _____ FEMALE [] MALE []

SINGLE [] MARRIED [] DIVORCED [] WIDOWED [] SPOUSE/PARENT _____

SPOUSE/PARENT EMPLOYER: _____ SPOUSE/PARENT WORK PHONE (____) _____

PRIMARY INSURANCE _____ POLICY# _____ GROUP# _____

SUBSCRIBER'S NAME _____ SUBSCRIBER'S DATE OF BIRTH _____

SECONDARY INSURANCE _____ POLICY# _____ GROUP# _____

REFERRAL SOURCE _____

FAMILY PHYSICIAN _____

WHAT IS THE REASON FOR TODAY'S VISIT _____

What is the location of the problem _____ How long have you had this problem _____

IF CONDITION IS DUE TO ACCIDENT/INJURY, PLEASE GIVE DATE _____

All insurance Co-pay amounts are expected at the time of service. A \$3.00 rebilling charge will be posted to all unpaid balances after 60 days. All cosmetic procedures require payment in full 3 weeks prior to the procedure date. I understand that Thomas Meeks, D.O. is the owner of the Olympic Plastic Surgery Suite

I, the undersigned, certify that I, or my dependant, have insurance coverage with _____ and assign directly to the Olympic Plastic Surgery Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Meeks to release all information necessary to secure payment benefits. I authorize the use of this signature on all insurance submissions. In the event legal action should become necessary to collect any unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney fees or other such costs as the Court determines proper. I agree that the venue for any legal action shall be in Kitsap County.

I have received a written copy of the Patient's Bill of Rights.

Patient/Responsible Party Signature _____ Date _____

Witness Signature _____ Date _____

MEDICAL INFORMATION

Height _____ Weight _____ Could you be **pregnant**? Yes [] No [] Maybe []

Are you **allergic** to any drugs or medications? _____ If so, which drug(s) and type of reaction _____

Are you currently taking any **medications**? _____ If so, please list _____

History of previous **illnesses** with dates _____

History of previous **surgery** with dates _____

Do you **smoke**? No [] Yes [] If yes, how much _____

Do you drink **alcohol**? No [] Yes [] If yes, how much _____

Do you use recreational **drugs**? No [] Yes [] If yes, how much _____

Have you ever taken **cortisone** or **steroids**? No [] Yes [] If yes, when? _____

Have you taken **Accutane** (prescribed for acne) in the past 2 years? NO [] YES []

DO YOU HAVE AN ADVANCE DIRECTIVE / LIVING WILL NO [] YES []

IF NO, WOULD YOU LIKE MORE INFORMATION NO [] YES []

HAVE YOU EVER HAD ANY OF THE FOLLOWING? IF YES, PLEASE EXPLAIN IN SPACE PROVIDED.

YES NO

DIABETES [] [] _____

HEART TROUBLE/CHEST PAIN [] [] _____

HIGH BLOOD PRESSURE [] [] _____

STROKE [] [] _____

PHLEBITIS /VARICOSE VEIN PROBLEMS [] [] _____

TROUBLE BREATHING/COUGHING [] [] _____

EYE TROUBLE (glaucoma, dryness, etc.) [] [] _____

KIDNEY OR BLADDER PROBLEMS [] [] _____

ABDOMINAL PROBLEMS [] [] _____

BLEEDING TENDENCIES (from surgery, cuts, dental work, etc) [] [] _____

HEALING PROBLEMS AFTER CUTS, SURGERY, ETC. [] [] _____

EASY BRUISING [] [] _____

ANEMIA [] [] _____

JAUNDICE [] [] _____

HEPATITIS [] [] _____

HIV or AIDS [] [] _____

NERVOUS CONDITION [] [] _____

CANCER [] [] _____

ACUTE INFECTIONS [] [] _____