BRZOWSKI PLASTIC SURGERY

Brian K. Brzowski, MD, FACS

PATIENT DEMOGRAPHIC INFORMATION

Today's Date:________________

Patient's Name:____

Date of Birth:____________________ Age:______ SSN:__________________

Street Address:____

City/State/Zip:____

Home Phone:________________ Work:_______________ Cell:______________

Preferred Number for Contact:____

E-mail Address:____

Married:__________Single:____________ Divorced:________Widowed:_________

Spouse:____

Guardian's Name (If Patient Under 18):_________________________________

Emergency Contact:____Phone:________________

Relationship:____

How did you hear about Brzowski Plastic Surgery?

____

The web is becoming a key way patients learn about our practice. Do you participate in any of the following (check all that apply)

- ☐ Yelp
- ☐ Facebook
- ☐ Twitter
- ☐ Real Self
- ☐ Blogging if yes, where can we see it? http://________________________

What website(s) did you find helpful to use in researching our practice or procedure?

____

Revised 1/18/2012

Patient History Intake (PS)

Today's Date:

Patient Name: ______________________ **Birth Date:** __________
Age: _______

Important: In order to provide the highest quality of health care possible, it is important that we have the following information. Please answer all of the doctor's questions as accurately as possible. If you do not understand the question please ask for assistance. Thank you.

Please describe the reason(s) for this visit: ______________________

____

Review of Systems:

Do you have now or have you had within the past year:

Const	Weight Gain/Loss	no	yes
	Fever	no	yes
	Fatique	no	yes
Eyes	Dry eyes	no	yes
	Vision changes	no	yes
ENT	Mouth sores	no	yes
	Sore throat	no	yes
	Ringing in ears	no	yes
	Sinus headaches	no	yes
Resp	Persistent cough	no	yes
	Coughing blood	no	yes
	Wheezing	no	yes
	Shortness of breath	no	yes
CV	Shortness of breath with activity	no	yes
	Difficulty breathing lying down	no	yes
CV	Chest pain	no	yes
	Rapid heart beat	no	yes
	Swollen hands/feet	no	yes
Skin	Skin rash	no	yes
	Painful breasts	no	yes
	Breast lumps	no	yes
	Nipple discharge	no	yes
GI	Persistent diarrhea	no	yes
	Bloody stools	no	yes
	Nausea, vomiting	no	yes
	Constipation	no	yes
	Bloating/gas	no	yes
	Abdominal pain	no	yes
ALL	Hives, blisters	no	yes
	Red, itchy eyes	no	yes
	Persistent sore throat	no	yes
Psych	Depression	no	yes
	Mood swings	no	yes
	Sleep Disturbances	no	yes
Neuro	Seizures	no	yes
	Frequent headaches	no	yes
	Dizziness	no	yes
	Numbness	no	yes
MSK	Joint or muscle pain	no	yes
	Muscle weakness	no	yes
Lymph	Swollen lymph nodes	no	yes
Heme	Easy bleeding	no	yes
	Easy bruising	no	yes
Endo	Night sweats	no	yes
	Hot/cold intolerance	no	yes
Other	______________		
	______________		
	______________		

For female patients only:

Age period began ____________

Date of last mammogram ____________

Do you do regular breast self-examinations?

Number or pregnancies __________

Did you breast feed? no yes

Breast lump or discharge no yes

Drug allergies: ______________________

____

List any medications you are taking, including non-prescription drugs, vitamins, and herbals:

____

____

Past Medical History:

Have you ever had the following:

Heart disease	no	yes
Arthritis	no	yes
Rheumatic Fever	no	yes
Anemia	no	yes
Tuberculosis	no	yes
Diabetes	no	yes
Allergies	no	yes
Cancer	no	yes
Glaucoma	no	yes
Asthma	no	yes
AIDS or HIV+	no	yes
Stroke	no	yes
Hepatitis	no	yes
Stomach Ulcer	no	yes
Kidney disease	no	yes
Thyroid Disease	no	yes
Bleeding tendency	no	yes
Mitral Valve Prolapse	no	yes
High Blood Pressure	no	yes

List any other surgeries or major illnesses and dates: ______________________

____

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Family History:

Has any blood relative ever had the following:

Breast Cancer.............	no	yes	High blood pressure .	no	yes	Kidney disease	no	yes
Melanoma	no	yes	Heart Disease	no	yes	Depression	no	yes
Stroke	no	yes	Diabetes	no	yes			

Social History:

Occupation: ______________________________

Smoking (type & amount per day)___________ Alcohol (type and amount per week)______

If former smoker, date quit:_______________ Weight__________________Height________________

To ensure confidentiality and privacy, any type of electronic recording is strictly prohibited at any location within these offices. Thank you for your understanding and compliance.

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X ____________________________________ ______________________________

SIGNATURE OF PATIENT OR PARENT IF MINOR **DATE**

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ___________________________, understand that as part of my health care, Brzowski Plastic Surgery originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges.

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Brzowski Plastic Surgery is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Brzowski Plastic Surgery reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Brzowski Plastic Surgery change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

Persons to Whom Information May Be Disclosed
Information listed above may be disclosed to:

____

____

Name of persons or Organizations

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

_______________________________ _______________________________

Patient Signature Date of Signature