

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?

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	CV	Chest painno yes	Psych	Depressionno yes
	Fever no yes		Rapid heart beat.....no yes		Mood swings.....no yes
	Fatigue no yes		Swollen hands/feet ...no yes		Sleep Disturbances.....no yes
Eyes	Dry eyes no yes	Skin	Skin rashno yes	Neuro	Seizuresno yes
	Vision changes..... no yes		Painful breastsno yes		Frequent headaches ...no yes
ENT	Mouth sores no yes		Breast lumpsno yes		Dizzinessno yes
	Sore throat no yes		Nipple discharge no yes		Numbnessno yes
	ringing in ears no yes	GI	Persistent diarrheano yes	MSK	Joint or muscle painno yes
	Sinus headaches no yes		Bloody stools.....no yes		Muscle weaknessno yes
Resp	Persistent cough no yes		Nausea, vomitingno yes	Lymph	Swollen lymph nodes ...no yes
	Coughing blood no yes		Constipationno yes	Heme	Easy bleedingno yes
	Wheezing no yes		Bloating/gasno yes		Easy bruisingno yes
	Shortness of breath.... no yes		Abdominal pain.....no yes	Endo	Night sweatsno yes
CV	Shortness of breath	ALL	Hives, blisters.....no yes		Hot/cold intolerance ...no yes
	with activity.....no yes		Red, itchy eyes.....no yes	Other	_____
	Difficulty breathing		Persistent sore throat.no yes		_____
	lying downno yes				_____

For female patients only:

Age period began _____

Number of pregnancies _____

Date of last mammogram _____

Did you breast feed? no yes

Do you do regular breast self-examinations?

Breast lump or discharge no yes

Drug allergies: _____

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

Past Medical History:

Have you ever had the following:

Heart diseaseno yes	Cancerno yes	Stomach Ulcerno yes
Arthritisno yes	Glaucomano yes	Kidney diseaseno yes
Rheumatic Feverno yes	Asthmano yes	Thyroid Diseaseno yes
Anemiano yes	AIDS or HIV+no yes	Bleeding tendencyno yes
Tuberculosisno yes	Strokeno yes	Mitral Valve Prolapseno yes
Diabetesno yes	Hepatitisno yes	High Blood Pressureno yes
Allergies.....no yes		

List any other surgeries or major illnesses and dates: _____

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

**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