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

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