



**REGISTRATION FORM**

<b>Section I:</b>	<b>Patient Information</b>	<b>Date</b> _____
Name: _____ I Prefer to be called: _____		
Address: _____ City: _____ State: _____ Zip _____		
Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____		
The best time to contact me is: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. on my <input type="checkbox"/> Home phone <input type="checkbox"/> Work phone <input type="checkbox"/> Cell phone		
Date of Birth: _____ Social Security Number: _____		
Check Appropriate Box: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
If Student, Name of School _____ City/State _____ <input type="checkbox"/> FT <input type="checkbox"/> PT		
Spouse or Parent's Name: _____ Employer _____ Work Phone _____		
Whom may we thank for referring you? _____		
Person to contact in case of emergency _____ Phone _____		
Email Address _____ Would you like to receive our e-newsletter? <input type="checkbox"/> Yes <input type="checkbox"/> No		

<b>Section II</b>	<b>Responsible Party</b>
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Name: _____ Relationship to Patient: _____	
Address: _____	
City: _____ State: _____ Zip: _____ Phone: (____) _____	
Employer _____ Work Phone (____) _____ SSN# _____	

<b>Section III</b>	<b>Insurance Information</b>
Name of Insured _____ DOB _____ Relationship to Patient _____	
SSN#: _____ Name of Employer: _____ Work Phone: (____) _____	
Address of Employer: _____ City _____ State: _____ Zip _____	
Insurance Company _____ Grp # _____ ID# _____	
Ins Co Address: _____ Ins Co. Phone: _____	
---- DO YOU HAVE ANY ADDITIONAL INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, COMPLETE THE FOLLOWING ----	
Name of Insured _____ DOB _____ Relationship to Patient _____	
SSN#: _____ Name of Employer: _____ Work Phone: (____) _____	
Address of Employer: _____ City _____ State: _____ Zip _____	
Insurance Company _____ Grp # _____ ID# _____	
Ins Co Address: _____ Ins Co. Phone: _____	



Cosmetic ■ Head/Neck ■ Reconstruction

## Section IV

## Medical History

The following personal history is absolutely confidential, but is imperative part of the our evaluation. Thank you.

Do you have any medical problems or have you had any hospitalizations? \_\_\_\_\_

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Have you had any surgeries? \_\_\_\_\_

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Do you take any medications including over the counter medications, herbal remedies, and vitamins?

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Do you smoke? YES  NO  If yes, how many packs a day, and for how many years? \_\_\_packs/day \_\_\_years

Do you drink? YES  NO  If yes, approximately how much, and how frequently? \_\_\_\_\_

Have you taken Accutane? YES  NO  If yes, how long ago did you quit? \_\_\_\_\_

Have you used any drugs or IV drugs? YES  NO

Do you have any allergies to medications? YES  NO  If yes, please list \_\_\_\_\_

Do you have any skin sensitivities or seasonal allergies? YES  NO

If yes, please list \_\_\_\_\_

Have you received general anesthesia before? YES  NO

Any problems or family history of problems with anesthesia? \_\_\_\_\_

Have you received local anesthesia before? YES  NO

Any problems with local anesthesia? \_\_\_\_\_

Are you a present or past carrier of a contagious disease? \_\_\_\_\_

Do you have a skin care regimen that you follow? \_\_\_\_\_

Any personal or family history of clotting problems, easy bruising, bleeding gums? \_\_\_\_\_

Have you taken Cortisone or Steroids in the past year?

Any chance you could be pregnant? YES  NO

Date of your last physical? \_\_\_\_\_ Last EKG \_\_\_\_\_ Last Chest XRay \_\_\_\_\_

Family Physician name \_\_\_\_\_

Anything else you would like us to know? \_\_\_\_\_

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DO YOU HAVE OR HAVE YOU EVER HAD:

YES NO

- Heart disease or heart trouble
- High blood pressure
- Lung disease
- Hay fever
- Kidney disease
- Liver disease
- Epilepsy/seizures/neurological problems
- Thyroid or goiter problems
- Chest pain
- Chronic cough
- Recent respiratory infection
- Skin trouble/infections/rashes/irritations
- Keloid or ugly scars
- Glaucoma
- Phlebitis
- Problems lying flat
- Nosebleeds
- Fainting
- Asthma
- Have you considered seeing a psychologist/  
therapist?
- Are you seeing a therapist now?
- Are you on a special diet?
- Recent weight loss (amount) \_\_\_\_\_
- Any exposure to a communicable disease in the last 3 weeks?

YES NO

- Mitral valve prolapse
- Diabetes
- Muscle weakness
- Difficulty urinating
- Jaundice
- Headache or dizzy spells
- Bowel/colon disease or problems
- Shortness of breath
- Back or neck trouble
- Ulcers/stomach trouble
- Do you use eye drops?
- Treatment of genital area
- Are you easily depressed
- Hiatal hernia
- Blood transfusion
- Ankle swelling
- Facial fractures
- Anemia
- Drug or alcohol dependency
- \_\_\_\_\_ Height
- \_\_\_\_\_ Weight



DO YOU HAVE ANY OF THE FOLLOWING: Dentures \_\_\_\_\_ Partial plate \_\_\_\_\_ Bridgework \_\_\_\_\_

ARE YOU WEARING ANY OF THE FOLLOWING: Contacts \_\_\_\_\_ False eyelashes \_\_\_\_\_ Hearing aid \_\_\_\_\_  
Wig/hairpiece \_\_\_\_\_ Permanent cosmetics \_\_\_\_\_

FAMILY HISTORY: Diabetes \_\_\_\_\_ Bleeding \_\_\_\_\_ Heart disease \_\_\_\_\_ Anesthesia problems \_\_\_\_\_  
Other \_\_\_\_\_

<p><b>Signed</b> _____</p> <p><b>Date</b> _____</p>
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**AUTHORIZATION AND ASSIGNMENT OF BENEFITS (Please sign both)**

I authorize Raghu Athre, MD to furnish information to insurance carriers only concerning my illnesses and treatments.

Date \_\_\_\_\_ Signature \_\_\_\_\_

I assign to Raghu Athre, MD all payments for medical services rendered to me or my dependent. I understand that I am responsible for any amount not covered by assigned insurance.

Date \_\_\_\_\_ Signature \_\_\_\_\_

A photocopy of this authorization and assignment shall be considered as valid as the original.

It is customary to pay for professional services when rendered. Itemized receipts will be furnished on request. Patients are asked to file for routine office visits with their respective insurance companies. In the event of surgery, it is the patient's responsibility to furnish us with appropriate insurance forms on which to file surgery charges. The patient is responsible for all fees, regardless of insurance coverage.



PHOTOGRAPHY CONSENT

I hereby give my permission to Raghu Athre, MD or any assistant he may designate, to take photographs for diagnostic purposes, to enhance the medical report, during surgery, and postoperatively for evaluation purposes. I agree that these photographs will remain his property.

Date \_\_\_\_\_ Signature \_\_\_\_\_

I further authorize him to use such photographs for teaching purposes or to illustrate scientific papers, books, or lectures if, in his judgement, medical research, education, public education, or science will be benefited by their use. It is specifically understood that in any such publication or use, I shall not be identified by name.

Date \_\_\_\_\_ Signature \_\_\_\_\_

I further authorize him to use such photographs for advertising purposes. It is specifically understood that in any such publication or use, I shall not be identified by name.

Date \_\_\_\_\_ Signature \_\_\_\_\_

If my pictures are used for advertising purposes, (select one)

I would like identifying marks blacked out

I do not mind if identifying marks are not blacked out