Jane Rowley, MD
PLASTIC SURGERY

Emergency Information *Please identify the name of a person who does not live with the patient*

Name _____ Phone (_____)_____ Relationship to Patient_____

Other Information

Have you been a patient in this office before this occasion? ❍ Yes ❍ No When _____

If yes, who was your doctor at that time? _____

Were you treated at a hospital at that time? ❍ Yes ❍ No

When _____ By whom _____

Please allow our receptionist to copy your insurance cards

1st Insurance to be filed: ❍ Group ❍ Individual ❍ Auto ❍ Medicare ❍ Medicaid ❍ Other

Insurance Co. Name _____

Insured's Name_____ S.S.N. _____-_____-_____

Policy # _____ Group Name/Number _____

Mailing Address for Claim _____
Street or P.O. Box City State Zip

2nd Insurance to be filed: ❍ Group ❍ Individual ❍ Auto ❍ Medicare ❍ Medicaid ❍ Other

Insurance Co. Name _____

Insured's Name_____ S.S.N. _____-_____-_____

Policy # _____ Group Name/Number _____

Mailing Address for Claim _____
Street or P.O. Box City State Zip

Due to the high cost of billing, we must request payment for all office visits at the time of service. If you wish to file your own insurance claim, we will provide sufficient information on your paid receipt for you to do so. Insurance is a contract between you and your carrier. We are happy to contact the insurance carrier to facilitate payment on your behalf. We welcome questions concerning fees.

I accept responsibility as Guarantor for the above named patient. I authorize release of any medical information necessary to process claims for services rendered. I assign, transfer, and set over to Jane Rowley, MD, PA all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize payment of these benefits to Jane Rowley, MD, PA. I accept responsibility for any balances unpaid by my insurance company.

_____

Signature (Patient or Authorized Person) Date

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Medical Information (continued)

Please list any medications (prescription or over-the-counter) that you have taken within the last month.

Please specify: _____

_____

_____

Please list the names and year of any operations you have ever had:

_____

_____

_____

_____

_____

Serious injuries or accidents

_____

_____

_____

_____

_____

Are you presently on or have you taken any diet or appetite suppressant pills in the last six months. Please list:

_____

_____

Name any drugs to which you are allergic:

_____

_____

_____

Have you ever had any complications from anesthesia? Y N

Explain: _____

_____

_____

Do you frequently have bleeding gums? Y N

Do you have nose bleeds? Y N How often? _____

Have you ever bled excessively from a tooth extraction? Y N

Do you bleed excessively from a laceration? Y N

Do you take aspirin regularly? Y N How often? _____

If yes, stop taking them until after your surgery

Have you had blood transfusions? Y N Any adverse reactions? _____

Women Only

Is there any chance you may be pregnant? Y N

Are you still having regular monthly menstrual periods? Y N Date of last menstrual period: _____

Date of last mammogram: _____ Results: _____

How many children? _____

We recommend routine breast and pelvic exams by your physician for all adult females.

Office Use Only

B/P _____ P _____ R _____ T _____

Pre-Operative Photos? Y N Taken by: _____

Laboratory tests completed? Y N

Instructions / orders to patient: _____

_____

Comments: _____

Surgery: Date: _____ Time: _____ Location: _____

Jane Rowley, MD
PLASTIC SURGERY

Patient Medical History

Date _____

CONFIDENTIAL INFORMATION: Information contained herein will not be released except when you have authorized us to do so. Please answer ***all*** questions to the best of your knowledge. The information that you provide will be used by your doctor in his decisions regarding your care.

Patient Information

Patient's Name _____ (Last) _____ (First) _____ (Middle) DOB ____/____/____ Age _____

Ht. _____ Wt. _____ Sex ○M ○F ○ Single ○ Married ○ Widowed ○ Divorced

Physician Information

Referring Physician: Address:

Family Physician: Address:

Oncologist: Address:

Pediatrician: Address:

Send correspondence to: Address:

Last physical exam M.D.: Date of Last Physical Exam: _____

Medical Information

Do you have or have you had: (circle - if yes, give date of occurrence)

AIDS or HIV+	No	Yes_____	Congenital Heart	No	Yes_____	Leukemia	No	Yes_____
Arthritis	No	Yes_____	Diabetes	No	Yes_____	Migraine	No	Yes_____
Asthma	No	Yes_____	Epilepsy	No	Yes_____	Nervous Breakdown	No	Yes_____
Back Problems	No	Yes_____	Goiter	No	Yes_____	Pneumonia	No	Yes_____
Bladder Infection	No	Yes_____	Hay Fever	No	Yes_____	Rheumatic Heart	No	Yes_____
Bleeding Tendency	No	Yes_____	Heart Attack	No	Yes_____	Stomach Ulcers	No	Yes_____
Bronchitis	No	Yes_____	Hepatitis	No	Yes_____	Stroke	No	Yes_____
Cancer	No	Yes_____	High Blood Pressure	No	Yes_____	Tonsilitis	No	Yes_____
Colitis	No	Yes_____	Kidney Disease	No	Yes_____	Tuberculosis	No	Yes_____

Other serious illnesses that you have had:

Do you regularly smoke? Y N How much? Do you regularly drink 6 or more cups of coffee per day Y N

Do you regularly drink alcohol or beer? Y N How much? Date of last chest x-ray:

Are you presently taking any of the following medications? (circle)

Antibiotics	Cortisone	Insulin or diabetic pills	Sleeping pills
Aspirin, Bufferin, Anacin	Cough medicine	Iron or poor blood medication	Thyroid medicine
Barbituates	Digitalis	Laxatives	Tranquilizers
Birth control pills	Dilantin	Medicine for arthritis	Water pills
Blood pressure pills	Headache pills	Phenobarbital	Weight-reducing pills
Blood-thinning pills	Hormones	Shots	Other drugs not listed

_____

Do you know of any blood relative who has or had: (circle and give relationship)

Arthritis	_____	Epilepsy	_____	Mental Illness	_____
Asthma	_____	Goiter	_____	Migraine	_____
Bleeding tendency	_____	Hay fever	_____	Nervous breakdown	_____
Breast cancer	_____	Heart attack	_____	Rheumatic heart	_____
Other cancer	_____	High blood pressure	_____	Stomach ulcers	_____
Colitis	_____	High fever after surgery	_____	Stroke	_____
Congenital heart disease	_____	Kidney disease	_____	Suicide	_____
Diabetes	_____	Leukemia	_____	Tuberculosis	_____

Jane Rowley, MD
PLASTIC SURGERY

Date _____ Dr# _____

Account # _____ Doctor _____

How did you hear about Jane Rowley, MD, PA?

Referring Physician - Name _____ Other - Name _____

Address _____ Address _____

Physican's Phone (_____) _____ _____

Patient Information

Patient's Name _____ DOB ___/___/___ Age _____
Last First Middle

Mailing Address _____
Street/Apt.

_____
City State Zip

S.S.N. ___ - ___ - ___ Sex ❍ M ❍ F ❍ Single ❍ Married ❍ Widowed ❍ Divorced

Home Phone (_____) _____ Work Phone (_____) _____ E-mail _____

Employer's Name _____ Occupation _____

Employer's Address _____
Street City State Zip

Do you have (primary) insurance through your employer ❍ Yes ❍ No

If yes, please provide additional information requested on the reverse side of form.

Your reason for visiting the doctor today

_____

Spouse Information

Spouse's Name _____ DOB ___/___/___ Age _____
Last First Middle

Home Phone (_____) _____ Work Phone (_____) _____ S.S.N. ___ - ___ - ___

Employer's Name _____ Occupation _____

Employer's Address _____
Street City State Zip

Do you have (secondary) insurance through your spouse's employer ❍ Yes ❍ No

If yes, please provide additional information requested on the reverse side of form.

Parent or Guardian Information *(For patient who is a minor)*

Is patient covered by insurance through father's employer ❍ Yes ❍ No
Is patient covered by insurance through mother's employer ❍ Yes ❍ No

If yes, please provide additional information requested on the reverse side of form.

Parent/Guardian's Name _____ DOB ___/___/___ Age _____
Last First Middle

Mailing Address _____
Street City State Zip

Father

Father's Name _____
Last First Middle

Employer _____

Employer's Address _____
Street

_____
City State Zip

Employer's Phone (_____) _____

DOB ___/___/___ S.S.N. ___ - ___ - ___

Mother

Mother's Name _____
Last First Middle

Employer _____

Employer's Address _____
Street

_____
City State Zip

Employer's Phone (_____) _____

DOB ___/___/___ S.S.N. ___ - ___ - ___