PROSERPI-SCHLECHTER CENTER FOR PLASTIC SURGERY (610) 678-9200

Patient Information as of ________________ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name ____

Last First Middle

Address ____

Street & Apt # City State Zip

Home Phone __________________ Cell Phone __________________ Other Phone __________________

Any restrictions for contacting you? ❒ No ❒ Yes E-mail ______________________________

Contact Restrictions: ____________________________ Drivers License # (include State) ______________________

Age _______ Birthdate ___/___/___ SS# ___-___-_____ Sex ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: ______________________ Race: Religion: ______________

Patient's Employer ______________________ Occupation ______________________

Work Phone __________________ Ext: ________ Is it okay to call you at work? ❒ Yes ❒ No

Address ____

Street & Suite # City State Zip

Emergency Contact
(Not in your household) ______________________ Relationship to Patient ______________________

Home Phone __________________ Work Phone __________________ Other Phone __________________

Address ____

Street & Apt # City State Zip

Primary Care Physician

Name ______________________________

Primary Health Insurance Company ______________________________

Policy # __________________ Group # __________________ Ins. Phone __________________

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $__________

Insured: Name __________________ DOB __________________ Employer __________________

Secondary Health Insurance Company ______________________________

Policy # __________________ Group # __________________ Ins. Phone __________________

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $__________

Insured: Name __________________ DOB __________________ Employer __________________

How did you hear about us? ____

Detailed reason for office visit ____

____

Were you seen by another Doctor for this condition? If you were, by whom and when? ______________________

____

MEDICAL HISTORY
Please indicate if you are being treated for any of the following conditions:

High blood pressure:_____ Diabetes______Heart Condition_____Asthma_____Cancer_____

Mitral Valve Prolapse_____HIV positive_____Other(explain)___________________________

Please list any past surgery with the date:____

____

Height________ Weight_______

Are you right or left handed_________

Do you have any known drug allergies or sensitivities? If yes, please list:______________________________

____

Are you taking aspirin or any medication containing aspirin? If yes, please list:

____

List the medications you are presently taking:

DRUG STRENGTH TIMES PER DAY SPECIAL INSTRUCTION

1.____

2.____

3.____

4.____

FOR ACCIDENTS, PLEASE COMPLETE:

Type of Accident: Automobile Employment Other (please explain):______________

____

For automobile only: with whom, if a passenger:____

Date and time incident occurred:____

Give specific details of accident, including where it occurred:____

____

If you were treated in the ER, when and where:____

Attending Doctors:____

Transported by ambulance or automobile:____

Were you admitted?____

Date of discharge:____