AYDIN PLASTIC SURGERY PATIENT REGISTRATION

Date _____

Patient's Name _____
First Middle Last

Address: _____

Home Phone: _____ **Cell Phone**_____**Email:** _____

Any restrictions for contacting you? Yes No. **Please list** _____

DOB _____**Soc. Sec No**.: _____**Sex:** Female Male

Marital Status: _____**Race** _____

Patient's Employer: _____**Occupation**_____

Address: _____

INSURANCE INFORMATION – Please give your insurance card and ID to the Front Desk

_____

Primary Insurance **Address of Ins. Co.:** **Ins. Phone**

_____

Subscriber's Name: **Sub. DOB** **Group No.** **Policy No.:**

Patient's relationship to subscriber (Circle One) **Self** **Spouse** **Other**_____

EMERGENCY CONTACT

Name_____Relationship to Patient_____

Home Phone _____Cell Phone_____Work phone_____

Address:_____

How did you hear about us? Check one and please be as specific as possible

____Physician _____ ___Family Member/Friend _____
____Magazine _____ ___Billboard _____
____Radio/Pandora _____ ___Train/Bus _____
____Instagram _____ ___Facebook _____
____Google ____RealSelf ___Other _____

WHY ARE YOU HERE TODAY? _____

OTHER AREAS OF INTEREST (please circle)

Botox/Fillers	Nose Surgery	Liposuction
Hair Removal	Facelift	Brachioplasty
Pigmentation/Spot Treatments	Eyelid Surgery	Thigh Lift
PhotoFacials	Brow Lift	Buttock Lift with Aug
Facial Skin Tightening	Chin Augmentation	Mommy Makeover
Facial skin lift	Breast Surgery	Cellulite Treatment
Skin Care/Anti-aging Products	Tummy Tuck	SculpSure Non-invasive Fat Redution

MEDICAL HISTORY: It is important that you answer all of the following completely and honestly. Circle where appropriate.

Primary Care Physician _____**PCP Phone** _____

Please any Allergies/Sensitivities along with associated reaction _____

_____

Egg Allergies? Yes No **Milk Allergies?** Yes No

Have you been exposed to the sun in the past 3 weeks? Yes No

Are you taking any medications at this time? Yes No

Patient Name: _____

Please list all medications/supplements you take on a regular basis, including blood thinners such as aspirin, motrin, fish oil, Plavix, etc: _____

_____

Do you smoke? Yes No **How Much?** _____

Alcohol Consumption? Yes No **How much?** _____

Coffee Tea Consumption? Yes No **How much?**_____

Are you on a restricted diet? Please explain:_____

Are you currently pregnant? Yes No **Are you currently breast feeding?** Yes No

Are you planning a pregnancy? Yes No

Please list your pregnancy history _____

Please list your surgical history _____

_____

Have you been treated with chemical peels, lasers or Accutane? Yes No

Cardiac History – Please circle

Have you ever suffered from the following? Heart Attack Chest Pain Heart Disease Stroke TIA (Mini Stroke) High Blood Pressure

Do you have a pacemaker? Yes No

Have you ever had: Cardiac Stents? Yes No **Bypass Surgery?** Yes No

Do you suffer from Asthma? Yes No **How is it managed?**_____

Have you ever suffered from DVT or Pulmonary Embolism (clots in lungs/legs)? Yes No

Do you suffer from Epilepsy or have ever experienced seizures? Yes No

Do you suffer from Diabetes? Yes No

How is your diabetes controlled? Diet tablets insulin injections

Please check any of the pertinent medical conditions/issues below

Anemia	
Bleeding Tendency	
Cancer	
Leukemia	
Kidney Disease	
Liver Disease	
Multiple Sclerosis	
Depression	
Bipolar Disorder	
HIV/AIDS	
Colitis	
Tuberculosis	
Hepatitis	

Migraines	
Emphysema	
Hay Fever/Sinus Problems	
Recent Weight Change	
Change in appetite	
Wheezing/shortness of breath	
Swollen Legs/Feet	
Abdominal Pain	
Fatigue/Weakness	
Keloid Scarring	

Please list any other medical conditions and/or history that we should know about:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

***I hereby acknowledge that all of the above information has been answered honestly and to the best of my ability. I will update the doctor with any medical changes that may occur.**

Signature: _____ Date: _____
Printed Name: _____

***RELEASE OF MEDICAL RECORDS:** I hereby authorize Dr. Aydin to release my medical information to my insurance company if requested.
Signature_____Date: _____

***IF PATIENT IS A MINOR:**
I give permission for _____to receive treatment from Aydin Plastic Surgery
Name of Patient
Signature Parent or Guardian_____Date:_____