

FACIAL PLASTIC & COSMETIC SURGICAL CENTER

PATIENT REGISTRATION FORM

The following information will help us to serve you better. Please make every effort to fill out the information fully and accurately. Please be sure to complete both sides of the form. Your responses are held strictly confidential.

PERSONAL INFORMATION

NAME _____
DATE OF BIRTH _____ AGE _____ SEX _____ SSN _____
HOME ADDRESS _____ APT# _____
CITY _____ STATE _____ ZIP _____
TELEPHONE Home (_____) - _____
Cell (_____) - _____
Work (_____) - _____
If you would like to be on our email mailing list please include email address below: _____
Single () Married () Separated () Divorced () Widowed ()
Where Employed? _____ Occupation? _____
Education *highest year completed* _____
Name of Spouse or Parent _____ how many children _____
Spouse or Parent's occupation _____
Spouse or Parent's employer _____
In Case of Emergency, contact: _____
Relationship: _____ phone (_____) - _____
Who is responsible for charges? _____

Please circle below the primary type of surgery you are interested in discussing today:

NOSE FACE EYELID NECK MOUTH EARS SCARS CHEEKS CHIN WRINKLES
BREAST ENLARGEMENT BREAST REDUCTION TUMMY TUCK LIPOSUCTION
OTHER _____

Please use this space to give us any other information you feel would be helpful for your consultation.

WHY DID YOU SELECT OUR CENTER? Please indicate all that apply () General reputation or recommendation
() Patient referral. May we ask who? _____ May we acknowledge referral? () yes () no
() Doctor referral. May we ask who? _____ May we acknowledge referral? () yes () no
() Speaking engagement. Where? _____ () Magazine. Which? _____
() Newspaper () Yellow pages () Web site (please indicate how you found us below) () Other (please indicate below)

The medical history is an extremely important part of your consultation. It helps to alert us to any potential problems that might interfere with your surgery. Please take the time to fill this out completely and accurately. If you need some help, the staff will be glad to assist you.

List all herbal or natural supplements you are taking: _____

List all prescription drugs you are taking: _____

List any non prescription drugs you take (i.e. aspirin, cold tablets, etc.) _____

List any diet pills you take very important! *Can cause serious problems with anesthesia* _____

Please tell us about any serious illnesses you have had in the past for example, heart disease, blood pressure problems, Pulmonary disease, kidney disease, diabetes, thyroid trouble, stomach ulcers, etc. _____

Please list any operations you have had (including cosmetic surgery). _____

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Are you allergic to any drugs? yes () no () If yes, please list: _____
List any contact allergies including latex or other products _____
Describe any injuries you have sustained, include dates _____
Describe any difficulties you have had with anesthesia _____
Are there any hereditary disorders in your family of significance? _____
Do you smoke? _____ If so, what form and how much? _____
How much alcohol do you drink? () none () occasional () moderate () heavy
How is your general health? _____ Are you under a doctor's care? _____

Please review the list below and check anything applicable. You may use the space to the right for any explanation that you think would be helpful. Please be as complete as possible.

- () Severe dryness of the eyes
- () Glaucoma or blurry vision
- () Recurrent severe dizziness
- () Severe headaches
- () Chronic Sinus problems or nasal blockage
- () Recurrent fever blisters
- () Paralysis of the face
- () Asthma or emphysema
- () Chronic hoarseness
- () Shortness of breath
- () Chest pain
- () Heart disease or high blood pressure
- () Chronic abdominal problems
- () Kidney or bladder problems
- () Blood in bowel movements
- () Blood in urine or trouble urinating
- () Easy bruising
- () Menstrual disorder
- () Abnormal lump or node
- () Problems with bones or joints
- () Unexplained weight loss
- () Cancer
- () Emotional problems
- () Chronic skin condition
- () Complications after surgery
- () Bad surgical result or unsatisfactory medical care

Height _____
Weight _____

Notice Concerning Complaints
Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturist, may be reported for investigation at the following address: Texas Board of Medical Examiners; Attention: Investigations; 1812 Centre Creed Drive, ste 300; P. O. Box 149134; Austin, Texas 78714-9134 Assistance in filing a complaint is available by calling the following telephone number: 1 888 973 0022

Aviso Sobre Quejas
Se pueden presentar quejas acerca de medicos, asi tambien como de otras personas autorizadas y registradas pro la Junta de Examinadores Medicos del Estado de Texas (Texas State Board of Medical Examiners), incluyendo a ayudantes medicos y acupunturistas, para su investigation, en la siguiente direccion: Texas Board of Medical Examiners; Attention: Investigations; 1812 Centre Creek Drive, ste 300; P. O. Box 149134; Austin, Texas 78714-9134 Se puede obtener ayuda para presentar una queja llamando al siguiente numero telefonico: 1 888 973 0022

Post Doctoral Clinical Fellow spend a year training at our Center. They will assist in your surgery although Dr. Tobin will always be the principal surgeon unless patients request otherwise. If, for any reason, you do not wish to have the Fellows present during your consultation, initial here: _____

I have read and complete this form completely and accurately to the best of my ability:

Date this form completed _____ Signature _____