IF THIS IS YOUR FIRST VISIT, PLEASE TAKE THE TIME TO FILL THIS FORM OUT COMPLETELY.

Patient Name: _____ Age: _____ Date of Birth: _____ Weight: _____ Height:_____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
E-mail address _____ Emergency Contact _____
Emergency Contact Info_____
Emergency Contact relationship to you_____
Social Security#: _____ Occupation: _____
How did you hear about us? _____
Reason for today's visit: _____

Primary Care Physician: _____ Phone: _____ Fax_____
Address_____City/State_____Zip_____

Referring Physician: _____Phone: _____ Fax_____
Address_____City/State_____Zip_____

Primary Insurance:_____ Phone #:_____
Address:_____ Policy #: _____ Group #: _____
Policy Holder:_____ Social Security #: _____ DOB:_____

Secondary Insurance: _____ Phone #:_____
Address:_____ Policy #: _____ Group #: _____
Policy Holder:_____ Social Security #: _____ DOB:_____

PAYMENT OPTIONS:

- MasterCard & Visa are accepted
- Personal checks are accepted at least 14 days prior to surgery
- Payment financing is available via Care Credit

- Who is your current treating physician? _____
- How many migraine headaches do you experience per month on average? _____
- How many regular headaches do you have per month on average? _____
- How painful are your migraine headaches? (Circle One Number)
  1 2 3 4 5 6 7 8 9 10
- Mild Severe
- How long do your migraine headaches usually last? _____
- Where are your migraine headaches usually located? (check all that apply)

  □ behind right eye □ behind left eye □ behind both eyes
  □ right temple □ left temple □ both temples
  □ above right eyebrow □ above left eyebrow □ above both eyebrows
  □ back of head on right □ back of head on left □ back of head both sides

- How old were you when your migraine headaches started? _____
- How would you describe your migraine headaches? (check all that apply)
  □ throbbing/pounding □ ache/pressure □ like a tight band □ other
- Do your migraine headaches awaken you at night? (check one)
  □ never □ occasionally □ often
- Do any of the following occur before or during your migraine headaches?
  □ nausea/vomiting □ runny nose □ bothered by light/noise
  □ blurry/double vision □ flashing/colored lights □ puffy eyelids
  □ other _____
- Do any of the following bring on your migraine headaches or make them worse?
  □ stress □ bright lights □ weather changes
  □ loud noise(s) □ heavy lifting □ fatigue
  □ other _____
- Do any of the following make your migraine headaches better?
  □ rest □ exercise □ quiet/darkness
  □ pressure on head □ massage □ vomiting
  □ other _____
- If you are female, do your migraine headaches change with any of the following?
  □ menstrual periods/pregnancy □ birth control pills/ other hormones

- Have you ever had a head or a neck injury requiring medical treatment?
  □ no □ yes If yes, describe _____
- Have you had your migraine headaches evaluated by a neurologist?
  □ no □ yes If yes, by whom and when _____
- What was the diagnosis? (check all that apply)
  □ migraine □ tension-type □ cluster □ other (specify) _____

- List all past tests you had for your migraine headaches: _____
  _____

- List all past treatment(s) for your migraine headaches: _____
  _____

- To what extent do your migraine headaches affect your quality of life? (check one)
  □ extremely □ moderately □ very little □ none at all

- What activities in life have you given up because of your headaches? _____
  _____

Do **you currently** have any of the following conditions?

	YES	NO		YES	NO		YES	NO
EYES			**ENDOCRINE**			**GENITOURINARY**		
Cataract(s)	❑	❑	Insulin dependent diabetes	❑	❑	Pain w/ urination	❑	❑
Visual disturbance(s)	❑	❑	Diabetes controlled with pills	❑	❑	Kidney/bladder infection	❑	❑
Glaucoma	❑	❑	Diabetes controlled with diet	❑	❑	Kidney stone(s)	❑	❑
Retinal problems	❑	❑	Thyroid disease	❑	❑	Hysterectomy	❑	❑
EAR, NOSE, THROAT			Parathyroid disease	❑	❑	Blood in urine	❑	❑
Sore throat	❑	❑	Psychiatric disorders	❑	❑	Uterine fibroids	❑	❑
Chronic sinus drainage	❑	❑	**CARDIAC**			**MUSCOLOSKELETAL**		
Nasal breathing issues	❑	❑	Heart disease	❑	❑	Joint Pain/Swelling	❑	❑
RESPIRATORY			Heart attack	❑	❑	Herniated disk	❑	❑
Use oxygen at home	❑	❑	Angina	❑	❑	Arthritis	❑	❑
Emphysema	❑	❑	Heart failure	❑	❑	Back pain/injury	❑	❑
Asthma	❑	❑	Hypertension	❑	❑	**NEUROLOGIC**		
GASTROINTESTINAL			Pacemaker	❑	❑	Stroke	❑	❑
Chronic nausea	❑	❑	Cardiac bypass	❑	❑	TIA (AKA “minor stroke”)	❑	❑
Chronic vomiting	❑	❑	Cardiac catheterization	❑	❑	Migraines	❑	❑
Abdominal pain	❑	❑	Angioplasty	❑	❑	Neuropathy	❑	❑
Diarrhea	❑	❑	High cholesterol	❑	❑	**SKIN**		
Black/bloody stools	❑	❑	**HEME/LYMPH**			Moles	❑	❑
Hepatitis	❑	❑	Recent lymph node swelling	❑	❑	Poor scarring	❑	❑
Gall stones	❑	❑	Chronic lymph node swelling	❑	❑			
Hernia(s)	❑	❑						
Spleen problems	❑	❑						

PAST MEDICAL HISTORY:
Have **you ever** had any of the following?

Anemia	❑ Yes	❑ No	Heart murmur	❑ Yes	❑ No	Mitral valve prolapse	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Rheumatic fever	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No	Skin cancer	❑ Yes	❑ No
Bleeding problem	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Kidney Disease	❑ Yes	❑ No	High blood pressure	❑ Yes	❑ No	Thyroid disease	❑ Yes	❑ No
Cancer (other)	❑ Yes	❑ No	HIV/AIDS	❑ Yes	❑ No	Seizures	❑ Yes	❑ No

If yes to any of the above, please describe the condition:_____
_____
_____

PAST SURGICAL HISTORY (including cosmetic surgery):
Please list any previous surgery with approximate dates:

Procedure	Date	Procedure	Date

FAMILY HISTORY:
Do you have **family members** with any of the following conditions:

Breast Cancer	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No
Other Cancer	❑ Yes	❑ No	Stroke	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No
MIGRAINES	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Depression	❑ Yes	❑ No

If yes to any of the above, please describe the condition and identify your relation to the family member:_____
_____
_____

MEDICATIONS:
Please list any prescription, non-prescription, and herbal medications you are taking along with doses. If you have a long list, please bring it to us.

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

DRUG ALLERGIES: _____

SOCIAL HISTORY:
Marital Status: _____ Spouse's name _____
Are you currently employed? yes ___ no ___ If so, what do you do?_____
Do you smoke? yes ___ no ___ If so, how many packs per day? _____
If you smoked in the past, when did you quit? _____
On average, how many alcoholic drinks do you have per week? _____

OFFICE & INSURANCE BILLING AUTHORIZATION AND NOTIFICATION

By my signature below, I am authorizing LANDIS PLASTIC SURGERY to bill my insurance company for services provided. Occasionally, insurance companies send the insured party (yourself) reimbursement directly for medical services provided by their doctors. In such an event, any monies received directly by me for services rendered by Dr. Landis will be forwarded to this office within 2 weeks of receipt. In addition, any co-pays or deductibles will be paid in full within 2 weeks of any procedure or office visit as applicable. I further understand that Dr. Landis may or may not be a participating provider with my insurance plan. As such, the allowed amount according to my insurance company for any services/procedures rendered may be less than the amount charged by LANDIS PLASTIC SURGERY and I acknowledge that the difference will be my responsibility. I also acknowledge and understand that there will be a fee of $25.00 (per form up to 4 pages and an additional $25.00 fee for each additional 4 pages of paperwork over the initial 4 pages) to complete any paperwork associated with my care. Finally, any appointments not cancelled **AT LEAST 24 HOURS** prior to the scheduled time will be subject to a $50 cancellation fee. I further acknowledge that any questions regarding these matters have been answered by Dr. Landis and/or his staff.

_____

Printed Name

_____ _____

Signature Date

If not signed by patient, please indicate relationship to patient (e.g. spouse)

_____

Relationship

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have been presented with a copy of Landis Plastic Surgery's 'Notice of Privacy Practices' detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of these 'Practices', and I request the following restriction(s) concerning the use of my personal medical information:

_____
_____
_____
_____

Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

_____
Printed Name

_____ _____
Signature Date

If not signed by patient, please indicate relationship to patient (e.g. spouse)

_____
Relationship