

**NEW PATIENT HISTORY AND MEDICAL INFORMATION FORM:**

Today's Date: \_\_\_\_\_

Patients First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Sex: \_\_\_\_\_ M \_\_\_\_\_ F Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**MEDICAL HISTORY:**

\*\*\*\*This portion of your medical record is kept strictly confidential\*\*\*\*

Reason for consultation: \_\_\_\_\_

Allergies: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_ Reactions: \_\_\_\_\_

Are you currently taking Vitamin "E"? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are you currently taking Aspirin Products or any type of Blood Thinners on a regular basis? \_\_\_ Yes \_\_\_ No

Do you bruise easily? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you ever had a reaction to injections of Local Anesthesia ? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you become nauseated after General Anesthesia? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you become lightheaded or nauseated at the site of needles or injections \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you get nauseated easily? \_\_\_\_\_ Yes \_\_\_\_\_ No Please give reason ? \_\_\_\_\_

\_\_\_\_\_ Date of last Physical Exam: \_\_\_\_\_ Physician: \_\_\_\_\_

**SURGICAL HISTORY:**

Please list any prior major medical illness or injuries:

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Please list any prior surgeries history:

Surgery/Hospitalization	Year	Outcome	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any type of implants Facial or Body? \_\_\_\_\_ Yes \_\_\_\_\_ No

What type? \_\_\_\_\_ Date/Year \_\_\_\_\_

Have you had an Electrocardiogram in the past year? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please circle any medical conditions that may apply to you:

Cancer	Yes//No	Anemia	Yes//No
Diabetes	Yes//No	Eye Problems	Yes//No
High Blood Pressure	Yes//No	Low Blood Pressure	Yes//No
Heart Disease	Yes//No	Angina	Yes//No
Anemia of unknown cause	Yes//No	Clotting Disorder	Yes//No
HIV infection (a symptomatic)	Yes//No	AIDS	Yes//No
Stroke	Yes//No	Heart Attack	Yes//No
Congestive Heart Failure	Yes//No	Pacemaker	Yes//No
Neurological Disorders	Yes//No	Depression	Yes//No
Cold sores/Fever Blisters	Yes//No	Ulcers	Yes//No
Psychiatric Disorder	Yes//No	COPD	Yes//No
Rheumatic Fever	Yes//No	Asthma	Yes//No
Emphysema	Yes//No	Lung Disease	Yes//No
Tuberculosis	Yes//No	Thyroid Disease	Yes//No
Elevated Blood Cholesterol	Yes//No	Alcoholism	Yes//No
Hepatitis	Yes//No	Renal failure	Yes//No



**FAMILY HISTORY**

Do you have any Family History of Allergic Reactions to anesthesia? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have any Family History of bleeding or Clotting disorders? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you sunburn easily? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have any Family History of Skin Cancer? \_\_\_\_\_ Yes \_\_\_\_\_ No

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Persons authorized to discuss my protected medical information and receive copies of my medical history and records are :

Persons Name	Relationship	Date
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If certify that the information provided on this medical history is correct and complete. Further, I understand that providing incomplete and incorrect information may not only jeopardize my health but also render ineffective or harmful, any treatment I receive from Dr. S. Sule.

I certify that the information provided on this medical history is correct and complete. Further, I understand that providing incomplete and incorrect information may not only jeopardize my health but also render ineffective or possible harmful treatments.

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Patient or Guardian Signature

Date

**INSURANCE INFORMATION**

Person responsible for payment:

Name the way it appears on Insurance Card :

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other Phone \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ birthday \_\_\_\_\_ Social Security \_\_\_\_\_

E-mail Address- Our way of reminding you of your upcoming appointments:

E-Mail- \_\_\_\_\_

How did you hear about Dr Sule? Internet \_\_\_\_\_ A Friend \_\_\_\_\_ A Patient \_\_\_\_\_ Doctor \_\_\_\_\_

Other \_\_\_\_\_ May we send a thank you note to ? \_\_\_\_\_

**SUBSCRIBER: (Who is the Insurance under?) (same as above) \_\_\_ Yes \_\_\_ No**

Name the way it appears on Insurance Card :

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other Phone \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ birthday \_\_\_\_\_ Social Security \_\_\_\_\_

**INSURANCE CARD INFORMATION**

**(We will need a copy of your Insurance Card at the time of your office visit, if you do not have a card please make sure you contact your provider and get your Ins. ID and Group Numbers and bring it with you. Further all Co-pays and Deductibles will be do at the time of your office visit).**

Primary Insurance Carrier or Name of Ins company:

\_\_\_\_\_

Employer: \_\_\_\_\_

Ins. Co. Phone Number: \_\_\_\_\_

Ins Co ID or Policy Number \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holders Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patients relationship to Policy Holder \_\_\_\_\_

**Secondary Insurance Carrier or Name of Ins company:**

\_\_\_\_\_

Employer: \_\_\_\_\_

Ins. Co. Phone Number: \_\_\_\_\_

Ins Co ID or Policy Number \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holders Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patients relationship to Policy Holder \_\_\_\_\_

Is condition related to an accident \_\_\_Yes \_\_\_No Date of Injury: \_\_\_\_\_

Is this an Auto Accident? \_\_\_Yes \_\_\_No

Please describe injury briefly \_\_\_\_\_

\_\_\_\_\_

**INSURANCE AGREEMENT AND ACKNOWLEDGEMENT:**

I understand that I am financially responsible for charges not paid by my medical insurance and agree to pay the charges. I authorize any holder of medial information about me to release to any responsible health carrier, Texas Department of Insurance and/or the Social Security Administration or its intermediaries, any information for this or any related medical claim. 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 the Sule Facial Plastic Surgery Clinic MD PA (E.N.T.) **Initial** \_\_\_\_\_

Fees for all services performed are determined by Dr S. Sule alone. These fees are non-negotiable under any circumstances, by any party and payment must be received at the time of service. We will not barter nor accept products or services in exchange for surgery or treatments. Should a balance appear on your account after the date of service for any reason, you will be notified and required to pay those charges within 90 days of the notice. If after 90 days payment has not been received, your account will be reviewed and sent to an outside collection agency. In the event a check is written for services rendered and does not clear your bank account, your balance will then be reinstated and a \$50.00 Non-Sufficient Funds Fee will be added. **Init.**\_\_\_\_\_

I have read and understand the above policies. I understand that all fees paid are nonrefundable unless deemed medically necessary by Dr. S. Sule Proof of medical condition must be supplied to provide evidence of medical necessity and refund consideration. **(Forms of payment: Cash, Visa, MC, Amex. No Checks.)**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_