

Bloom Facial Plastic Surgery
Two Town Place, Suite 110
Bryn Mawr, PA 19010

THIS PATIENT INFORMATION FORM IS PART OF YOUR MEDICAL RECORD AND MUST BE COMPLETED IN ITS ENTIRETY
PATIENT INFORMATION FORM

NAME _____
(Last) (First) (Middle)

SS# _____ BIRTHDATE _____ SEX: M F MARITAL STATUS: S M D W P

HOME ADDRESS _____
(Street) (Apt) (City) (State) (Zip)

HOME PHONE _____ E-MAIL _____

WORK PHONE _____ CELL PHONE _____

OCCUPATION _____

EMPLOYER NAME _____

RESPONSIBLE PARTY INFORMATION: (IF OTHER THAN PATIENT)

NAME _____
(Last) (First) (Middle)

RELATIONSHIP TO PATIENT _____

SS# OF INSURED _____ BIRTHDATE OF INSURED _____

HOME ADDRESS _____
(Street) (City) (State) (Zip Code)

HOME PHONE _____

☐ I HAVE NO INSURANCE COVERAGE (PLEASE CHECK IF APPROPRIATE)

REFERRED BY ☐ PHYSICIAN ☐ FRIEND ☐ INTERNET ☐ OTHER PHONE # _____

ADDRESS _____

PRIMARY CARE PHYSICIAN _____ PHONE # _____

ADDRESS _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

PHONE _____

I do hereby agree to pay the full and entire amount of **all bills for services rendered.**

(Sign Name) (Date)

As a member of a managed care group, I assume all responsibility for any services rendered that are not a part of my referral, whether or not covered or paid by my insurance, and **I will pay for those services at the time they are rendered.**

(Sign Name) (Date)

WORKER'S COMPENSATION AND OTHER PERSONAL INJURY TESTIMONY IN COURT

In order to provide the best possible service, care and availability to all of our patients, **it is our policy not to testify in court, depositions, arbitrations, etc. relating to Worker's Compensation and other personal injury action.**

(Sign Name) (Date)

SPECIALIZED CARE

I understand that the Bloom Facial Plastic Surgery is a tertiary referral practice. The physicians at our office will evaluate the specific problem for which you have been referred or have sought treatment. General care and evaluation is the responsibility of the referring or primary physician.

(Sign Name) (Date)

Reason for visit_____

How long have you had this problem?_____

Areas of Interest: (mark all that apply)

Cosmetic Procedures

- ☐ Rhinoplasty (Nose Reshaping)
- ☐ Chin or cheek Implants
- ☐ Blepharoplasty (Eyelid Lift)
- ☐ Face or Neck Lift
- ☐ Midface Lift
- ☐ Brow or Forehead Lift
- ☐ Liposuction (Neck, Jowls)
- ☐ Otoplasty (Ear Pinning)
- ☐ Botox or Neurotoxins
- ☐ Injectable Fillers & Volumizers

- ☐ Lip Enhancement
- ☐ Facial Scars
- ☐ Earlobe Repair

Functional Procedures

- ☐ Nasal Obstruction
- ☐ Nasal / Facial Fracture
- ☐ Chronic Sinusitis
- ☐ Facial Nerve Spasm / Weakness
- ☐ Skin Cancer Repairs

Other Procedures

- ☐ Skin Care
- ☐ Lesions / Moles
- ☐ Telangectasia (spider veins)
- ☐ Skin Resurfacing (Laser, Peel, Etc.)
- ☐ Other _____

Have you ever been on **Accutane**? NO YES

Do you have or have a history of **Cold Sores**? NO YES

Do you have or have a history of **Scarring or Keloids**? NO YES

Do you have **regular menstrual cycles**? NO YES

Are you **pregnant** at this time? NO YES

Do you **faint** when having blood drawn? NO YES

REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY OF PATIENT (CHECK ALL THAT APPLY; USE C. IF CURRENT, USE P IF PAST)

CONSTITUTIONAL SYMPTOMS:

☐ Fever ☐ Hair loss
☐ Weight loss ☐ Weight gain
☐ Chills ☐ Tremor
☐ Nutritional Deficiencies
☐ Other, specify _____

EYES:

☐ Cataracts ☐ Glaucoma
☐ Eyestrain ☐ Blurring
☐ Inflammation
☐ Wear glasses
☐ Wear contacts
☐ Other, specify _____
Date of last eye exam _____

EARS, NOSE, MOUTH, THROAT:

☐ Hearing difficulty
☐ Pain ☐ Discharge
☐ Tinnitus (ringing in ears)
☐ Dizziness ☐ Wear hearing aid
☐ Sinusitis ☐ Postnasal drip
☐ Obstruction
☐ Gum Disease
☐ Chronic sores
☐ Herpes simplex infections
☐ Soreness ☐ Redness
☐ Hoarseness
☐ Other, specify _____

CARDIOVASCULAR:

☐ Stroke ☐ Palpitation
☐ Pacemaker ☐ Rheumatic Fever
☐ Faintness ☐ Pain
☐ High blood pressure
☐ Heart surgery
☐ Edema (swelling)
☐ Heart valve replacement
☐ Other, specify _____

INFECTIOUS:

☐ HIV Positive ☐ AIDS Virus
☐ Hepatitis

CANCER(S): (LIST TYPE, DATE, TREATMENT)

RESPIRATORY:

☐ Asthma ☐ Chest pain
☐ Emphysema ☐ Tuberculosis
☐ Lung disease
☐ Breathing disorder
☐ Bronchitis, chronic
☐ Sputum, with blood
☐ Cough, chronic
☐ Upper respiratory infection, chronic
☐ Other, specify _____

GASTROINTESTINAL:

☐ Ulcer ☐ Pain
☐ Nausea ☐ Constipation
☐ Diarrhea ☐ Vomiting
☐ Appetite decrease
☐ Colon/intestinal disorder
☐ Other, specify _____

GENTOURINARY:

☐ Discharge ☐ Urgency
☐ Sores ☐ Incontinence
☐ Hesitancy
☐ Herpes simplex infections
☐ Other, specify _____

MUSCULOSKELETAL:

☐ Arthritis ☐ Lupus
☐ Joint pain ☐ Lupus of the skin
☐ Weakness ☐ Joint swelling
☐ Joint replacement
☐ Cold sensitivity
☐ Other, specify _____

INTEGUMENTARY:

☐ Skin cancer(s)
☐ Acne ☐ Hives
☐ Warts ☐ Psoriasis
☐ Eczema ☐ Cystic Acne
☐ Loss of Pigment
☐ Contact dermatitis
☐ Malignant Melanoma
☐ Scarring/keloids
☐ Herpes simplex (cold sores)

☐ Herpes Zoster (shingles)
☐ Other, specify _____

NEUROLOGICAL:

☐ Headaches ☐ Convulsions
☐ Seizures ☐ Migraine
headaches
☐ Epilepsy ☐ Fainting spells
☐ Memory loss
☐ Other, specify _____

PSYCHIATRIC:

☐ Stress ☐ Depression
☐ Nightmares ☐ Insomnia
☐ Anxiety ☐ Suicidal Tendency
☐ Treatment of psychological disorder
☐ Other, specify _____

ENDOCRINE:

☐ Thyroid disorder
☐ Diabetes mellitus
☐ Excessive hair, face/body
☐ Other, specify _____

HEMATOLOGIC/LYMPHATIC:

☐ Anemia ☐ Bruise easily
☐ Blood clots ☐ Excessive bleeding
☐ Other, specify _____

ALLERGIC/IMMUNOLOGIC:

☐ Asthma ☐ Frequent
infections
☐ Allergies ☐ Thyroiditis
☐ Vitiligo ☐ Addison's Disease
☐ Pernicious anemia
☐ Hay Fever
Other, specify _____

MALES ONLY:

☐ Urinary difficulties
☐ Prostatic problems

FEMALES ONLY:

☐ Chronic vaginal infections
☐ Currently pregnant
☐ Currently taking oral contraceptives
Date of last menses _____

Please fill out the following:

What medical/cosmetic issue would you most like to discuss today?

HOSPITALIZATIONS:

None ☐

Reason:	Dates:
1.	
2.	
3.	

PAST SURGICAL HISTORY:

None ☐

Surgery:	Dates:
1.	
2.	
3.	

MEDICATION / VITAMINS / HERBAL: None ☐

Drug:	Reason:
1.	
2.	
3.	
4.	

Do you take aspirin or ibuprofen? YES ☐ NO ☐
Blood thinners / Coumadin? ☐ ☐

ALLERGIES TO MEDICATIONS: None ☐

Drug:	Reaction:
1.	
2.	
3.	

Environmental/Contact/Food Allergies YES ☐ NO ☐

If yes, which ones _____

Date of last medical check-up _____

Result _____

SOCIAL HISTORY: (Please indicate all that apply)

Consume alcohol excessively? YES ☐ NO ☐
Have you ever smoked? ☐ ☐
Used Cocaine? ☐ ☐
Used recreational IV drugs? ☐ ☐
Smoked Marijuana? ☐ ☐

Please fill out the following:

FAMILY HISTORY: (Please indicate all that apply)

Reactions to anesthesia YES ☐ NO ☐
Malignant Hyperthermia ☐ ☐
Bleeding tendencies ☐ ☐
Cancer ☐ ☐
Clotting disorders ☐ ☐

COSMETIC PROCEDURES:

Have you had any of the following?

Botox / Dysport / Neurotoxins YES ☐ NO ☐
Fillers (Juvederm/Restylane/Radiesse) ☐ ☐
Chemical Peel ☐ ☐
Laser Resurfacing ☐ ☐
Rhinoplasty ☐ ☐
Facelift / Necklift ☐ ☐
Bleph (Eyelids) / Browlift ☐ ☐
Liposuction ☐ ☐
Chin / Cheek Implant ☐ ☐
Facial Trauma / Plating ☐ ☐
Facial Reconstruction ☐ ☐

Do you have any children? YES ☐ NO ☐

How many?
How old?

List athletic activities:

List hobbies:

Have you ever been unhappy with the care of a physician? YES ☐ NO ☐

If Yes, Explain:

PATIENT INFORMATION FORM

THE PRACTICE FINANCIAL POLICY WILL BE GIVEN TO PATIENTS AT THE TIME OF REGISTRATION.

ALL PATIENTS MUST SIGN THIS FORM.

OUR PRACTICE FINANCIAL POLICY

The physicians and staff at our office are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made by either yourself or your health coverage carrier, full payment is due at the time of service. For your convenience, we accept Visa, MasterCard, American Express, Discover, cash and personal checks. We also reserve discretion to accept CareCredit.

YOUR INSURANCE

We have made prior arrangements with some insurers and other health plans. We will bill those plans with whom we have an agreement and will collect any required co-payment at the time of service. The co-payment will be collected when you arrive for your appointment. In the event your health plan determines a service will not be covered, you will be responsible for the complete charge. In that event, you will receive a statement at the time of service and payment is due at the time of service.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare a statement for you to attach to your insurance claim form for processing of payment. In this case, the insurance carrier will send the payment directly to you. Therefore, charges for your care and treatment are due at the time service is rendered.

Any balance due is your responsibility and is due upon receipt of a statement from our office.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

MISSED APPOINTMENTS

In order to provide the best possible service and availability to all our patients, we ask that you please call us as soon possible, if you know you will need to reschedule your appointment.

I have read and understand the financial policy of the practice and I agree to be bound by its items. I also understand and agree that such terms may be amended from time-to-time by the practice.

(Signature of the Patient or Responsible Party)

(Date)

(Please Print the Name of the Patient)