MAINE
PLASTIC SURGERY CENTER

PATIENT INTAKE FORM:

First Name:_____ M.I. _____ Last Name:_____ Date: _____/_____/_____

Date of Birth: _____/_____/_____ Marital Status (circle one) Single Married Widowed Divorced

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Work Phone: _____

Social Security: _____ Email: _____

Emergency Contact: _____ Relation: _____Phone: _____

Current Pharmacy or Preferred Pharmacy: _____

How did you select our office? (Check applicable boxes)

- ☐ Existing Patient
- ☐ Name: (info confidential) _____
- ☐ Family or Friend who is not a patient:
- ☐ Physician: _____
- ☐ Facebook/Instagram
- ☐ Other: _____

Financial Responsibility:

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for the services rendered, including reasonable attorney's fees and costs of collection in the event of default.

Date: _____/_____/_____ Signature: _____

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MEDICAL HISTORY AND PHYSICAL:

Patient Name: _____Date: ____/_____/_____

Height: _____ Weight: _____ BMI:_____

Age: _____ Date of Birth:_____ Occupation: _____

Primary Care Doctor: _____ Number:_____

Specialty Care Doctor: (if any) _____Number: _____

Date of Last Complete History & Physical: _____

Allergies: (Please list all allergies including latex, tape, medications, & food)

Allergic to: _____ Reaction: _____

Allergic to: _____ Reaction: _____

Medications: (Please list all Medications, Prescriptions, Birth Control, Supplements or Over The Counter or Herbal Remedies and Doses)

Medication: _____Dose: _____Medication:_____ Dose:_____

Medication: _____Dose: _____Medication:_____ Dose:_____

SOCIAL & PERSONAL:

- **Regular Aspirin Use:** □ Y □ N

(Dosage & frequency) _____

- **NSAID (Advil, Motrin, IBP):** □ Y □ N

(Dosage & frequency) _____

- **Cortisone Injection Past Year:** □ Y □ N

(Dosage & frequency) _____

- **Do you Vape or use Tobacco?** □ Y □ N

If yes, average # of packs a day_____

- **When was your last cigarette?** _____

Number of year's smoked_____Years Quit_____

- **Do you drink Alcohol?**

If yes, how many per week_____

- **Ever used LSD/Cocaine/Marijuana?** When:_____

Ever seek Drug Treatment? _____

- **Recent Weight Change?**

Increase Up:_____Decrease Down:_____

MENTAL HEALTH:

- Do you feel depressed? □ Y □ N
- Do you panic when stressed? □ Y □ N
- Do you have any problems with eating or appetite? □ Y □ N
- Do you cry frequently? □ Y □ N
- Have you ever attempted suicide? □ Y □ N
- Do you have trouble sleeping? □ Y □ N
- Have you ever been to a counselor? □ Y □ N
- Previously taken psychiatric medications? □ Y □ N

- **Exercise Regularly**: □ Y □ N

If so, how often?_____

- Can you walk a mile without stopping? □ Y □ N
- Walk up 2 flights of stairs without stopping? □ Y □ N

How Much? _____

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MEDICAL HISTORY

Have you ever had: (please check)

High Blood Pressure	□ Y	□ N
Chest Pain/ Edema/Swelling	□ Y	□ N
Heart Condition	□ Y	□ N
Stroke	□ Y	□ N
Palpitations	□ Y	□ N
MRSA	□ Y	□ N
Narcolepsy	□ Y	□ N
Multiple Sclerosis	□ Y	□ N
Muscle Spasm/back/neck pain	□ Y	□ N
Dark or chocolate colored urine	□ Y	□ N
Cold sores	□ Y	□ N
Thyroid Problems	□ Y	□ N
GI Disorders/Reflux/Heartburn	□ Y	□ N
Hepatitis	□ Y	□ N
Cancer	□ Y	□ N
HIV/AIDS or Kidney Disease	□ Y	□ N
Diabetes, if yes, take insulin?	□ Y	□ N

Other: _____

_____

Do you/family have a history of the following?

Unexpected death following general anesthesia or exercise?	□ Y	□ N
Malignant hyperthermia?	□ Y	□ N
Muscle or neuromuscular disorder?	□ Y	□ N
Clotting Problems?	□ Y	□ N
Fever following heavy exercise or anesthesia?	□ Y	□ N

Do you currently:

Have asthma/ COPD/Breathing Problems	□ Y	□ N
Experience shortness of breath?	□ Y	□ N
Snore loudly?	□ Y	□ N
Feel fatigued or sleepy during the day	□ Y	□ N
Has anyone observed that you stop breathing during your sleep?	□ Y	□ N
Have a diagnosis of Obstructive Sleep Apnea?	□ Y	□ N
(Use a CPAP?)	□ Y	□ N
Recent Cold or Flu?	□ Y	□ N
Recent Hospital Admission	□ Y	□ N

Women:

Last Period:_____

Last Mammogram:_____

SURGICAL HISTORY:

What surgeries have you had, and when?

_____

_____

_____

Local Anesthesia:_____

_____

General Anesthesia:_____

_____

Spinal/ Epidural:_____

_____

Previous nausea/vomiting with surgery? □ Y □ N

Have you ever had motion sickness? □ Y □ N

1685 Congress Street, Suite 301, Portland, ME 04102

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Authorization for Examination and Treatment:

Last Name:_____First Name:_____M.I._____

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____

Other Phone:_____

I _____present to the physician and staff that I am at least 18 (eighteen) years of age; or if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistants or staff as assigned by him or her.

Signature:_____**Date**:____/_____/_____

Relationship: (check one) ☐ Patient ☐ Spouse ☐ Parent ☐ Guardian

Authorization of Medical Information:

I authorize release of medical information to the following persons:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Signature: _____**Date**: _____/_____/_____

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HIPAA Release

Dear Patient:

Under the Patient Privacy Act we are giving you this form to update our files as well as ascertain your approval to provide future information on our services and the practices activities. It is our goal to keep all our patients abreast of not only what is happening in our practice, but any innovations within cosmetic surgery that might benefit you or your family and friends. Please complete the information below and return it to us prior to your appointment, along with your other paperwork. Also visit our website www.maineplasticsurgery.com to review our full Patient Privacy Policy. We also have a copy in our office for your convenience.

Please Print:

Name: _____

Please check your preferences for methods of contacts below:

☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-mail

I am interested in remaining on the patient contact list if the Plastic Surgery Center & Spa receiving information on upcoming seminars, new services, newsletters and other information on cosmetic surgery that might benefit my family or me.

I have received the Patient Privacy Policy (available to review on the website). ☐ Yes ☐ No

Signature: _____ **Date:** _____/_____/_____

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AMERICAN SOCIETY OF PLASTIC SURGEONS

I, _____, permit Dr. Jason Gardenier ("**my surgeon**") or his/her designee to take photos and/or videos before, during, and after my surgery. These may be of me or parts of my body ("**my images**"). I agree that my surgeon can share them with staff, other health professionals, and the public. This may be done for educational or marketing purposes.

I understand that once my images are published, I lose control over their use. I have no control over where they are published. I agree to give up certain rights to my image. I release any claim I may have to the publication of such images. This includes any payment for their distribution.

I understand that images posted online may be saved. They may be available forever. They may be found in online searches. I realize that people may repost my images without my surgeon's consent. This may be used in social media. Neither I nor my surgeon have any control over this. I agree that my surgeon is not responsible for third-party use. I release my surgeon from any claim that might arise from this use.

I agree that my surgeon can use my images in the following context:

Please initial <u>ONLY ONE</u> of the following:

_____ALL MEDIA: My images and medical details may be used in print and broadcast media. This includes newspapers, pamphlets, educational films, the internet (including social media and applications), and television.

_____WEBSITE ONLY: My images and medical details may be used on my surgeon's website.

_____ ALBUM ONLY: My images and medical details may be used in printed and/or digital photograph albums. The albums will only be used to show other patients my surgeon's methods.

I agree to the educational use of my images. I have fully read and understand the above terms. I have made my decision carefully and understand the risks.

PATIENT SIGNATURE: _____ Date: _____

Printed Name: _____

WITNESS SIGNATURE: _____ Date: _____

Printed Name: _____

For patients under the age of 18:

I, the parent or guardian of _____, a minor, am authorized to sign this release on his or her behalf. I agree to the educational use of his or her images.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

Printed Name: _____

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