

# 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** Prescriptions, Birth Control, Supplements, Over The Counter and Herbal Remedies)

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

GLP1/ Weight Loss:  Y  N Date of Last 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 use any form of Tobacco/Nicotine?**  Y  N

Type and Frequency \_\_\_\_\_

• **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

• Have you ever attempted suicide?  Y  N

• Do you have trouble sleeping?  Y  N

• Have you ever been to a counselor?  Y  N

• Previously/Currently taking 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

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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; Type: \_\_\_\_\_  Y  N  
Stroke  Y  N  
Palpitations  Y  N  
MRSA  Y  N  
Narcolepsy  Y  N  
Multiple Sclerosis  Y  N  
Back/neck pain  Y  N  
Reflux/Heartburn  Y  N  
Cold sores  Y  N  
Thyroid Problems  Y  N  
GI Disorders/Hiatal Hernia, Type: \_\_\_\_\_  Y  N  
Cancer, Type: \_\_\_\_\_  Y  N  
HIV/AIDS or Kidney Disease  Y  N  
Diabetes, if yes, take insulin?  Y  N  
Anemia  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  
Type: \_\_\_\_\_  
Bleeding /Clotting Problems  Y  N  
Type: \_\_\_\_\_  
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 an Inhaler  Y  N  
Use a CPAP Machine  Y  N  
Recent Cold or Flu  Y  N  
Recent Hospital Admission  Y  N  
Why? \_\_\_\_\_

### Women:

Last Period: \_\_\_\_\_

Last Mammogram: \_\_\_\_\_

## SURGICAL HISTORY:

### What surgeries have you had, and when?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Local Anesthesia: \_\_\_\_\_  
\_\_\_\_\_

General Anesthesia: \_\_\_\_\_

Previous nausea/vomiting with surgery?  Y  N

Have you ever had motion sickness?  Y  N

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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](http://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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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 ONLY ONE 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: \_\_\_\_\_