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: _____

1685 Congress Street, Suite 301, Portland, ME 04102

MAINE
PLASTIC SURGERY CENTER

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

MAINE
PLASTIC SURGERY CENTER

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

1685 Congress Street, Suite 301, Portland, ME 04102

MAINE
PLASTIC SURGERY CENTER

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**: _____/_____/_____

1685 Congress Street, Suite 301, Portland, ME 04102

MAINE
PLASTIC SURGERY CENTER

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:** _____/_____/_____

MAINE
PLASTIC SURGERY CENTER

AMERICAN SOCIETY OF PLASTIC SURGEONS

I, _____, permit my surgeon, treatment provider or his/her designee to take photos and/or videos before, during, and after my procedure. These may be of me or parts of my body. I agree that my provider 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 provider's consent. This may be used in social media. Neither I nor my provider have any control over this. I agree that my provider is not responsible for third-party use. I release my provider from any claim that might arise from this use.

I agree that my provider 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 provider'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 provider'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: _____

1685 Congress Street, Suite 301, Portland, ME 04102