

# PROSERPI-SCHLECHTER CENTER FOR PLASTIC SURGERY

(610) 678-9200

Patient Information as of \_\_\_\_\_ (enter today's date)  
(Please Print Legibly & Fill In or Correct All Fields)

## Patient's Name

\_\_\_\_\_ Last

\_\_\_\_\_ First

\_\_\_\_\_ Middle

Address \_\_\_\_\_

\_\_\_\_\_ Street & Apt #

\_\_\_\_\_ City

\_\_\_\_\_ State

\_\_\_\_\_ Zip

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Other Phone \_\_\_\_\_

Any restrictions for contacting you?  No  Yes

E-mail \_\_\_\_\_

Contact \_\_\_\_\_

Drivers License # \_\_\_\_\_

Restrictions: \_\_\_\_\_

(include State)

Age \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ Sex  Female  Male

Race: \_\_\_\_\_

Marital Status  Single  Married to: \_\_\_\_\_

Religion: \_\_\_\_\_

## Patient's Employer

\_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_

Ext: \_\_\_\_\_

Is it okay to call you at work?  Yes  No

Address \_\_\_\_\_

\_\_\_\_\_ Street & Suite #

\_\_\_\_\_ City

\_\_\_\_\_ State

\_\_\_\_\_ Zip

## Emergency Contact

(Not in your household)

\_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Other Phone \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Street & Apt #

\_\_\_\_\_ City

\_\_\_\_\_ State

\_\_\_\_\_ Zip

## Primary Care Physician

Name \_\_\_\_\_

## Primary Health Insurance Company

Policy # \_\_\_\_\_

Group # \_\_\_\_\_

Ins. Phone \_\_\_\_\_

Referral Required?  No  Yes

Copay?  No  Yes, \$ \_\_\_\_\_

Insured: Name \_\_\_\_\_

DOB \_\_\_\_\_

Employer \_\_\_\_\_

## Secondary Health Insurance Company

Policy # \_\_\_\_\_

Group # \_\_\_\_\_

Ins. Phone \_\_\_\_\_

Referral Required?  No  Yes

Copay?  No  Yes, \$ \_\_\_\_\_

Insured: Name \_\_\_\_\_

DOB \_\_\_\_\_

Employer \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Detailed reason for office visit \_\_\_\_\_

Were you seen by another Doctor for this condition? If you were, by whom and when? \_\_\_\_\_

**MEDICAL HISTORY**

Please indicate if you are being treated for any of the following conditions:

High blood pressure: \_\_\_\_\_ Diabetes \_\_\_\_\_ Heart Condition \_\_\_\_\_ Asthma \_\_\_\_\_ Cancer \_\_\_\_\_

Mitral Valve Prolapse \_\_\_\_\_ HIV positive \_\_\_\_\_ Other(explain) \_\_\_\_\_

Please list any past surgery with the date: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Are you right or left handed \_\_\_\_\_

Do you have any known drug allergies or sensitivities? If yes, please list: \_\_\_\_\_

Are you taking aspirin or any medication containing aspirin? If yes, please list: \_\_\_\_\_

List the medications you are presently taking:

<u>DRUG</u>	<u>STRENGTH</u>	<u>TIMES PER DAY</u>	<u>SPECIAL INSTRUCTION</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

**FOR ACCIDENTS, PLEASE COMPLETE:**

Type of Accident:      Automobile                      Employment                      Other (please explain): \_\_\_\_\_

For automobile only: with whom, if a passenger: \_\_\_\_\_

Date and time incident occurred: \_\_\_\_\_

Give specific details of accident, including where it occurred: \_\_\_\_\_

If you were treated in the ER, when and where: \_\_\_\_\_

Attending Doctors: \_\_\_\_\_

Transported by ambulance or automobile: \_\_\_\_\_

Were you admitted? \_\_\_\_\_

Date of discharge: \_\_\_\_\_