RENAISSANCE™
PLASTIC SURGERY
Fabulous at Any Age®

Date:_____

Full Name: _____ Age: _____ Birthdate ___/___/___ **M**___ **F**___
(Last, First) (Check one)

I prefer to be called: _____ Social Security #: _____-_____-_____ Marital Status: _____

Home Address: _____ Zip: _____ State: ____ Employer: _____

Home Phone: (_____) _____-_____ Mobile: (____) _____-_____ Work: (____) _____-_____

E-Mail Address: _____ Emergency Contact: _____ Relationship: _____

Home Phone: (_____) _____-_____ Mobile: (____) _____-_____ Work: (____) _____-_____

INSURANCE INFO:
Primary Insurance: _____ Secondary Insurance: _____
(Copy of Insurance Card Required)

Responsible Party:_____ Relationship: _____ Social Security #: _____-_____-_____

Home Address: _____ Zip: _____ State: ____ Employer: _____
(if different from above)

Birth date___/___/___ Is this a result of a work related injury? **Yes**____ **No**____ If yes, date of injury: _____

Do you smoke or use tobacco in any form?	Yes/No
Do you form large scars/keloids	Yes/No
Do you have frequent boils or infections?	Yes/No
Do you exercise regularly?	Never/Occasionally/Frequently
How often do you drink alcoholic beverages?	Never/Occasionally/Frequently
Previous cosmetic surgery?	
If yes, name of plastic surgeon:	_____

Are you allergiic to and medications or products? Yes/No

If yes, what? _____

List all current medications you are taking (including non-prescriptions & supplements)

_____

_____

Within the past year have you been under a physician's care? Yes/No Dermatologist? Yes/No

Name, address, and phone number of physicians:

_____

_____

Family and Personal Health History

Please identify any medical problems you or any blood relative have or have had

Condition	Self/Family Member(s)		
Asthma	_____	Lung Disease	_____
Anemia/Blood disorders	_____	Mental Disease/Disorder	_____
Birth Defects	_____	Muscle Disorder	_____
Bone/Joint Disorder	_____	Rheumatic Fever	_____
Cancer	_____	Rheumatoid Arthritis	_____
Diabetes	_____	Seizures	_____
Ear/Eye Disorder	_____	Skin Disease	_____
Heart Disease/Problems	_____	Thyroid Disease	_____
High Blood Pressure	_____	Tuberculosis (TB)	_____
HIV/AIDS	_____	Venereal Disease (VD)	_____
Kidney Disease/Problems	_____		

Pregnancy: (Past) _____ (Future?) _____ Number of Children_____ Height: _____ Weight: _____

Surgical History: _____

PLEASE NOTE: It is mandatory for patients (who smoke) to quit smoking two weeks prior to surgery and a MINIMUM of two weeks after surgery. IF YOU THINK YOU CANNOT REFRAIN FROM SMOKING THIS LONG PLEASE LET US KNOW.

Yes, I can refrain from smoking ____ No, I cannot ____

Doctor's Notes

Breast Patients Current Bra Size: _____ Goals _____ Last Mammogram_____

Nipple to Sternal Notch: (left) _____ (right) _____ Location of Exam _____

Base Width: _____ Nipple to Fold (left) _____ (right) _____

ONCOLOGIC DATA

Family Hx of Breast CA Y/N _____

PRIOR BREAST BIOPSIES/MASSES Y/N _____

Breast Pain Y/N _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any change in my medical or health insurance status. I am also aware that I am fully responsible for all medical expenses incurred and I agree to pay all charges submitted by this office during the course of treatment. I, the patient/responsible party authorize the release of any medical information required to process a claim for payment. I, the patient/responsible party authorize payment or medical benefits to the physician/supplier for services rendered.

_____ _____

Signature Date

_____ _____

Signature of Parent or Guardian Date

ONLY IF PATIENT IS A MINOR