A. PETER SALAS, M.D.,F.A.C.S., F.A.C.M.

Plastic Surgery

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PATIENT INFORMATION

Patient's Name:_____ Date: _____

Date of Birth:___/___/_____ Age:_____ Social Security Number:_____-_____-_____
Check appropriate box: Married ☐ Single ☐ Widow(er) ☐ Divorced ☐ Separated ☐
Check appropriate box: Male ☐ Female ☐

Email : _____
Home Phone : (_____) _____-_____ Emergency Contact Person:_____
Cell Phone : (_____) _____-_____ Emergency Contact Phone: (_____) _____-_____
Work Phone : (_____) _____-_____

Patient Address
Street:_____
City:_____ State:_____Zip:_____
Patient's Occupation:_____ Employer:_____
Employer's Address-Street:_____
City:_____ State:_____Zip:_____

Responsible Party
Name of person responsible for this account: _____
Date of Birth:___/___/_____ Age:_____ Social Security Number:_____-_____-_____
Relationship to patient: Self ☐ Spouse ☐ Parent ☐ Other ☐ (specify) _____
Address (if different from patient's home address)
Street:_____
City:_____ State:_____Zip:_____

Family Internist/Pediatrician:_____
Address-Street:_____
City:_____ State:_____Zip:_____
Phone Number: (_____) _____-_____

How did you learn about Dr. Salas: : Friend ☐ Physician ☐ Internet ☐ Other ☐ (specify)
Patient Referred by:_____
Address-Street:_____
City:_____ State:_____Zip:_____
Phone Number: (_____) _____-_____

DESCRIBE THE REASON FOR YOUR VISIT

Reason for visit: _____
If injury, date:_____ Type of injury:_____
At work? ❑ Yes ❑ No
Motor Vehicle? ❑ Yes ❑ No
If injury, where you treated by **DR. SALAS** at a Hospital for this injury? ❑ Yes ❑ No
If Yes, describe:_____

Do you have or have you had any significant emotional problems? ❑ No ❑ Yes _____
Have you ever had psychiatric/psychological care? ❑ No ❑ Yes _____
Have you ever been advised to see a psychiatrist? ❑ No ❑ Yes _____
Do you take any mind altering drugs? ❑ No ❑ Yes _____

Health Insurance

Plan Name: _____ ID #: _____ Group #:_____
Subscriber's Name:_____

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Subscriber's Name:_____

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS (PLEASE SIGN)

I, the undersigned,

- ☐ have insurance coverage (see information listed above)
- ☐ DO NOT have insurance coverage

I hereby authorize/designate the office of Dr. A. P. Salas, and/or whomever he may designate, to handle my insurance claims/appeals and all related issues for services rendered to me. Furthermore I authorize that payment of medical/surgical benefits be made directly to A. Peter Salas, M.D. I also consent that the office of A. Peter. Salas, M.D. be permitted to obtain/disclose any medical or other information regarding my son/daughter/spouse or myself needed to process this or future insurance claim(s). **I understand that, as the patient or the patient's responsible party, I am financially responsible to A. Peter Salas, M.D., for payment of all charges, regardless of my insurance carrier.** I further understand that payment for services rendered must be paid in full within sixty (60) days; otherwise I will incur service charges for which I am also financially responsible. If it should be necessary to turn my account over to an attorney or collection agency, the costs of collection will be added to my account and will be my financial responsibility. I am willing to allow photocopies or FAX of this authorization to be accepted with the same authority as the original. This authorization is to be regarded a continuing, valid authorization until such time as I specifically rescind it, in writing.

DATE:_____ SIGNED: _____
PRINT NAME: _____
DATE OF BIRTH: _____
PATIENT'S NAME: _____

Where an Attorney is involved

Attorney's name: _____
Address-Street:_____
City:_____ State:_____Zip:_____
Phone Number: (_____) _____-_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

DATE:_____ SIGNED: _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained becau

- o The patient refused to sign.
- o Due to an emergency situation it was impossible to obtain an acknowledgement.
- o We weren't able to communicate with the patient.
- o Other (Please provide specific details)

DATE:_____ SIGNED: _____

HEALTH HISTORY

(Confidential)

Name_____Today's Date_____

Date of Birth_____Date of last Physical Examination_____

Symptoms: Check symptoms you currently have or have had in the past year

General

- ❑ Chills
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Fever
- ❑ Forgetfulness
- ❑ Headache
- ❑ Loss of sleep
- ❑ Loss of weight
- ❑ Nervousness
- ❑ Numbness
- ❑ Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in:

- ❑ Arms
- ❑ Back
- ❑ Feet
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Neck
- Shoulders

Genito-Urinary

- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful urination

Gastrointestinal

- ❑ Appetite poor
- ❑ Bloating
- ❑ Bowel changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Vomiting blood

Cardiovascular

- ❑ Chest pain
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling of ankles
- ❑ Varicose veins

Eye, Ear, Nose, Throat

- ❑ Bleeding gums
- ❑ Blurred vision
- ❑ Crossed eyes
- ❑ Difficulty swallowing
- ❑ Double vision
- ❑ Earache
- ❑ Ear discharge
- ❑ Hay fever
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Persistent cough
- ❑ Ringing in ears
- ❑ Sinus problems
- ❑ Vision-flashes
- ❑ Vision-Halos

Skin

- ❑ Bruise easily
- ❑ Hives
- ❑ Itching
- ❑ Change in moles
- ❑ Rash
- ❑ Scars
- ❑ Sore that won't heal

Men only

- ❑ Breast lump
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penis discharge
- ❑ Sore on penis
- ❑ Other

Women only

- ❑ Abnormal Pap Smear
- ❑ Bleeding between periods
- ❑ Breast lump
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Nipple discharge
- ❑ Painful intercourse
- ❑ Vaginal discharge
- ❑ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Number of children_____

Have you had a Mammogram? _____

Are you pregnant? _____

Number of Children _____

Conditions: Check conditions you currently have or have had in the past.

- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High Cholesterol
- ❑ HIV Positive
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mesles
- ❑ Migraine Headaches
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Schlerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problem
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease

Medications	**Allergies to medications and substances**

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family

Relation	Age	State of health	Age at death	Cause of Death	Check if your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Hearth Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization

Have you ever had a blood transfusion? ☐ Yes ☐No
If yes, please give approximate date: _____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year	Sex	Complications if any

HEALTH HABITS Check which substances you use and how much

	Caffeine	
	Tobacco	
	Drugs	
	Other	

OCCUPATIONAL CONCERNS check if your work exposes to the following:

	Stress
	Hazardous substances
	Heavy lifting
	Other

Your Occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature Date

_____ _____
Reviewed by Date