

Please print clearly

Patient Name: _____ Date of Birth: ___/___/___ Age: _____
 Gender: ___F___M Social Security _____
 Street Address: _____
 City: _____ State: _____ Country: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____
 Email Address: _____ Work Phone: _____
 Employer: _____ Occupation: _____
 Marital Status: _____ Spouse Name (if Applicable): _____
 Emergency Contact Name: _____ Phone: _____

Please indicate how we may contact you: Please Circle

Home Telephone/ Answering Machine Yes – No Cell Phone/Voice Mail Yes - No
 Work Telephone/Voice Mail Yes – No Written Communication to home Yes - No

Primary Care Doctor: _____ Phone: _____
 Address: _____
 Referring Doctor: _____ Phone: _____
 If this Appointment work or auto related: YES _____ NO _____
 How did you hear about us: _____

Primary Insurance: _____ / _____ / _____ / _____				
Name of Insurance Company	Insurance Phone #	Referral Needed	Copay	
_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	
Policyholder's Last	First	Middle	Date of Birth	SS#
_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	_____ / _____ / _____ / _____
Insurance Contract #	Group #	Employer Name	Phone #	
_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	
Address of Policyholder (if different from patient)	City	State	Zip Code	Home Phone
_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	_____ / _____ / _____ / _____
Secondary Insurance: _____ / _____ / _____ / _____				
Name of Insurance Company	Insurance Phone #	Referral Needed	Copay	
_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	
Policyholder's Last	First	Middle	Date of Birth	SS#
_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	_____ / _____ / _____ / _____
Insurance Contract #	Group #	Employer Name	Phone #	
_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	_____ / _____ / _____ / _____	

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment, and any plans for future care or treatment. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I also allow fax transmittal of my medical records, if necessary. I acknowledge full financial responsibility for services rendered by Dr. Bruce Chau. I further authorize and request that insurance payments be made directly to Dr. Bruce Chau. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization. (If you would like a copy of our HIPPA notice please notify receptionist)

Signature: _____ Date: _____

Parent or Guardian if Minor _____

Patient Medical History Information

Name: _____ Height: _____ Weight: _____
 Date of Last Physical Exam: _____ Date of Last Mammogram (if applicable) _____
 Allergies: Yes - No If yes list with reaction they cause: _____

 Latex Allergy: Yes - No If yes reaction: _____

Surgical History

Date	Procedure

Current Medications:

Please give an explanation for the items checked yes

History of:	Yes	No	History of:	Yes	No
Hypertension			Diabetes		
Heart Valve Disorder			Asthma		
Heart Failure			Arthritis		
Bleeding Disorders			Thyroid Disease		
Tuberculosis/AIDS			Liver disease		
Phlebitis/Blood Clots			Anesthesia Problems		
History of Anemia			Cancer Self		
Sickle-Cell Anemia/Trait			Eye Problems		
Epilepsy/Seizures			Alcohol or Drug Abuse		
Kidney Disease			Smoking		

Any other medical issues:

Concerns you wish to address today:

I verify that the above information is true and accurate to the best of my knowledge and will notify Chau Plastic Surgery P.C. of any changes made to the above information as soon as possible.

Patient signature: _____ Date: _____

Parent or Guardian if minor: _____