Chau Plastic Surgery, P.C.
27901 Woodward Avenue, Suite 100 - Berkley, Michigan 48072
248.799.2880 phone - 248.414.3959 fax

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 ________________________________

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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:______________________________