



Patient Information Neil T. Chen, MD, Medical Director

Plastic and Reconstructive Surgery ♦ Aesthetic Surgery ♦ Surgery of the Hand

Last Name: _____ First Name: _____ Mid. Init. _____ Soc Sec #: _____
Date of Birth _____ Age _____ Occupation _____ Referral by _____
Address: _____ City _____ State _____ Zip _____
Phone (home) _____; (work) _____; (mobile) _____; Circle the best contact number
e-mail _____ May we e-mail you with appointment information? Y N; Future office events? Y N
Person to contact in an emergency _____ Phone _____ Relation _____
Family physician _____ When was your last physical exam? _____

Primary Insurance _____ Policy holder _____ Policy number _____
Address _____ Phone _____
Contact _____ Authorization by _____ No. of visits _____
Secondary Insurance _____ Policy holder _____ Policy number _____
Address _____ Phone _____
Contact _____

Work Comp Insurance _____ Claim No. _____
Address _____ Contact _____
Phone _____ Rehab Nurse _____ Phone _____
Employer _____ Contact _____ Date of injury/illness _____
Address _____ Phone _____

By signing below:
I verify that the above information is complete, true, and correct to the best of my knowledge
I agree to comply fully with my care, instruction, treatment and medication prescribed to me
I authorize the release of medical information to and from Dr. Chen deemed medically necessary for my treatment.
Specifically, I authorize release of my medical record to my referring physician and/or primary care physician and to my medical insurance company to the extent necessary for authorization for treatment and reimbursement of medical care.
I authorize the use of photography for the purpose of patient education, medical and other scientific research and publication
I agree to be responsible for all financial charges incurred as a result of my evaluation and treatment. Outstanding balance after 60 days is subject to monthly finance charge of 1.5% per month. I understand that the cost of collection in case of delinquency (90 days past due) will be added to my account.
I understand that this office is HIPPA compliant and I have read a copy of Patient Privacy Policy.
I agree that a copy of this document bearing my signature has the same effect as the original

Patient signature _____ **Date** _____
(Please fill out other side)

History Intake Form

Patient name: _____ **Date:** _____

Reason for visit _____ **Weight** _____ **Height** _____

Medications (including non-prescription drugs, vitamins and herbals): _____

Drug allergies: _____

What type of reactions: _____

List previous surgeries or major illness and dates: _____

Past Medical History: *Have you ever had the following? Please circle answers to each question.*

Heart attack	yes	no	Keloid scar	yes	no	Dry eyes	yes	no
Heart murmur	yes	no	Bleeding tendency	yes	no	Wear contact lenses	yes	no
Hypertension	yes	no	Stomach ulcer	yes	no	2+ alcoholic drinks/day	yes	no
Stroke	yes	no	Acid reflux	yes	no	6+ cups of coffee/day	yes	no
Asthma	yes	no	Rheumatoid disease	yes	no	AIDS or HIV+	yes	no
Diabetes	yes	no	Cancer: _____	yes	no	Pain syndrome (RSD)	yes	no
Thyroid disease	yes	no	Hepatitis	yes	no			
Anemia	yes	no	Smoking	yes	no			

Review of System: *Do you have now or have you had within the last year*

Chronic cough	yes	no	Jaundice	yes	no	Swollen lymph nodes	yes	no
Chest pain	yes	no	Depression	yes	no	Easy bleeding	yes	no
Rapid heart beat	yes	no	Seizures	yes	no	Ever had fever blister	yes	no

For **WOMEN** only:

Number of pregnancies: _____; number of children _____ Any chance you may be pregnant? Yes No
 Date of last mammogram: _____, results: normal abnormal

I verify that the above information is true and accurate to the best of my knowledge

X _____

Signature

Date

DO NOT WRITE BELOW version 01.06

