CENTER FOR PLASTIC &
RECONSTRUCTIVE SURGERY
Trust the Cosmetic Surgery Experts

Physician **(circle one)**: Paul Izenberg, MD David Hing, MD **Appointment Date:** ____________________
Richard Beil, MD Daniel Sherick, M.D. Ian Lytle, M.D.

Patient Information

Name:____ Prefix: ( ) Mr. ( ) Ms. ( ) Mrs. ( ) Miss ( ) Dr.
Last *First* *MI*

DOB:____/____/______ Sex: ( ) Male ( ) Female SSN:__________-________-__________
Month Day Year

Race: ( ) American Indian/Alaska Native ( ) Asian ( ) Black/African American ( ) Declined
( ) Native Hawaiian/Pacific Islander ( ) Other Race ( ) Unknown ( ) Caucasian

Religion: _________________________ Ethnicity: ( ) Hispanic or Latino ( ) Not Hispanic or Latino

Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Widowed Primary Language:___________________

Address:____
Street *City* *State* *Zip*

Phone: Home:_______________ Cell: _______________ Work:_______________ Fax:_________________

Primary Phone(check one): ( ) Home ( ) Cell ( ) Work Email address:_____________________________

Other Information:

Emergency Contact:___________________________________ Phone #: _________________________________
Name *Relationship to Patient*

Preferred Pharmacy:____
Name *Street* *City* *Zip* *Pharmacy Telephone #*

Reason for Visit:____

Is injury… work related? ( ) Yes ( ) No -or- auto related? ( ) Yes ( ) No Date of Injury:_____/___/________

Work/Auto Claim Billing Address :____
Name *Street* *City* *State* *Zip*

Physician Information: Please provide the name, telephone, and address for the physician(s) who provide your care:

PCP/Family Physician:____
Last *First* *Telephone #* *Street* *City* *State* *Zip*

Referring Physician:____
Last *First* *Telephone #* *Street* *City* *State* *Zip*

Medical Oncologist:____
Last *First* *Telephone #* *Street* *City* *State* *Zip*

Radiation Oncologist:____
Last *First* *Telephone #* *Street* *City* *State* *Zip*

I authorize CPRS to correspond with the physician(s) listed above concerning my condition and treatment plan.
(Check one): ( ) Yes ( ) No If "no", please list the reason(s) you do not wish your doctor to correspond with your other physicians:____

Signature: ____ Date_________________________
Patient or Responsible Party if Patient is under Age 18

Insurance Information: PLEASE GIVE YOUR INSURANCE CARDS TO THE RECEPTIONIST FOR COPYING

Primary Insurance:____

Secondary Insurance:____

If your medical insurance is in someone else's name, please complete the "Insurance Subscriber" Information:

Subscriber's Name:_______________________________ Relation to Patient:______________

Last *First* *MI*

Subscriber's Address:____

Street *City* *State* *Zip*

Subscriber's : DOB:___/___/_____ Sex: ( ) Male ( ) Female SSN:______-_____-________

Subscriber's Employer:_________________________ Subscriber's Phone #:________________

Please review and sign Sections I thru III below:

I. **Terms of Payment Acknowledgement:** I understand that Drs. Izenberg, Hing, Beil, Sherick & Lytle participate with Blue Cross/Blue Shield of Michigan (Tradiational, PPO Trust*, & Blue Preferred Plus), Blue Care Network (HMO), Priority Health (HMO/PPO), HAP (HMO, POS, HAP Senior Plus), Worker's Compensation, Medicare, Auto, ChampusTricare, and Medicaid with professional referral. Your insurance claims will be filed for you. If you have insurance other than those listed above, we may accept assignment on certain procedures. Patients are responsible for copays, deductibles, cosmetic services, and all non-insurance covered charges.

Name: (Print)____

Signature: ____________________________________ Date:____________

Patient or Responsible Party if Patient is under age 18

II. **Authorization to Release Information*:** I authorize the release of any medial information necessary to process insurance claims for my treatment or information acquired in the course of the examination or hospitalization.

Name: (Print)____

Signature: ____________________________________ Date:____________

Patient or Responsible Party if Patient is under age 18

*A photocopy of this authorization shall be considered as effective and valid as the original signed form.

III. **Acknowledgement of Receipt of Notice of Privacy Practices:** I further acknowledge receiving a copy of the Center for Plastic & Reconstructive Surgery, P.C. Notice of Privacy Practices on the date below.

Name: (Print)____

Signature: ____________________________________ Date:____________

Patient or Responsible Party if Patient is under age 18

How did you learn about our practice?

[ ] Physician:_______________________ [ ] Hospital:_______________________

[ ] Another Patient:__________________ [ ] Friend:_________________________

[ ] Website [ ] Seminar [ ] Telephone Directory:_______________

[ ] Publication *(circle one)*: New Beauty / Ann Arbor.com / AA Observer / Other:____________

[ ] Other (i.e., Employee, Attorney, Referral Line):______________________________

May we send you ongoing information? (Please Circle) via email? **Yes** **No** via U.S. Mail? **Yes** **No**

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Patient Name:____ Appointment Date:_____________

To your knowledge, do you **now** or have you ever **had** any of the following?

N	Y		N	Y		N	Y	
		Anemia			Frequent Nose Bleeds			Mitral Valve Prolapse
		Anesthesia Problem/ incl. family			Head Injury:____________			Morbid Obesity
		Arthritis			Headaches/Migraines			Multiple Sclerosis
		Asthma			Heart Attack/Pain (Angina)			Nervous Breakdown
		Auto-Immune Disease			Heart Failure			Pacemaker
		Bleed Easily			Heart Murmur or Defect			Phlebitis
		Blood Clots			Hepatitis B			Polio/Meningitis
		Blood Disorder(s)			Hepatitis C			Rheumatic Fever
		Blood Transfusion			Herpes			Scoliosis
		Bruise Easily			High Blood Pressure			Shortness of Breath
		Cancer			HIV Positive/AIDS			Sleep Apnea: CPAP? Yes/No
		Caps/Dentures/Bridges			Intertrigo/Skin Irritation/Ulcer			Stroke(weakness/paralysis)
		Diabetes			Irregular Heart Beats			Tuberculosis
		Emphysema			Kidney/Bladder Disease			Ulcers of Stomach or Bowel
		Epilepsy/Seizures			Liver Disease			Other:______________
		Fainting Spells			Loose/Missing Teeth			

Approximate date & provider of most recent physical exam:____

Please list all surgeries and major hospitalizations: ( ) **If none, please check.**

Date	Procedure	Reason	Place

Medications: Please list all medications you are presently taking (include dosage and frequency).

Medication	Dosage	Frequency

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Medications (continued)

When did you last take aspirin, Motrin, Advil, Aleve, ibuprofen, Alka-Seltzer or other pain medication (excluding Tylenol)?____

Do you now take or have you recently taken any of the following? Yes / No If yes, please specify.

Anti-depressants:______________________________ Birth control pills:______________________________

Arthritis medications:___________________________ Diet pills:____________________________________

Herbal products (*eg*, Metabolife, Appendrine, Comfrey, Garlic, Gingko, Chamomile, St. John's Wort, Kava, Sassafras):____

____

Please list all Allergies: ( ) **If none, please check.**

N	Y	Allergen	If yes, Specify	N	Y	Allergen	If yes, Specify
		Penicillin				Latex	
		Codeine				Other drugs/medications:	
		Aspirin				Other Allergy:	
		Local Injected Anesthetic					
		Iodine					
		Surgical tape					

Family Medical History

Any family illness(es)? If so, please explain____

____

If parent(s) is(are) deceased, please provide age and cause of death:

Mother:____

Father:____

Social History

Occupation:____________________________________ Employer:______________________________

Employer Address:____

Street *City* *State* *Zip*

Tobacco Products: ( ) Never ( ) Former ( ) Current; Frequency: ( ) Every Day ( ) Some Days; Packs per day:________

Alcohol Consumption: ( ) Never ( ) Former ( ) Current; Frequency: ( ) Every Day ( ) Some Days; Drinks per wk.:_____

Are you or could you be pregnant? Yes / No Are you ( ) Left handed or ( ) Right handed?

Specify religious/ethical concerns regarding surgery or blood transfusions?______________________________

____

Does your occupation or social activity place you at risk for ( ) Hepatitis B, ( ) Aids, or ( ) Tuberculosis? If so, explain:

____

Patient's Signature____**Date**______________

Patient or Responsible Party if Patient is under Age 18