PATIENT REGISTRATION

aesthetic. reconstructive. microsurgery.

TODAY'S DATE

Patient Information

LAST NAME | FIRST NAME | MIDDLE INITIAL | BIRTHDATE

STREET ADDRESS

CITY | STATE | ZIP

HOME PHONE | WORK PHONE | CELL

EMAIL | SOCIAL SECURITY NUMBER

MAY WE EMAIL EVENT SPECIALS & NEWSLETTERS TO YOU? ☐ Yes ☐ No

REFERRING PHYSICIAN | PRIMARY CARE PHYSICIAN

PHARMACY

How did you hear about Dr. Eko?

Insurance Information

EMPLOYER | OCCUPATION

ADDRESS | MARITAL STATUS

PRIMARY INSURANCE COMPANY | POLICY NUMBER

GROUP NUMBER | NAME OF PERSON INSURED | SOCIAL SECURITY NUMBER

ELIGIBILITY PHONE NUMBER | COPAY

SECONDARY INSURANCE COMPANY | POLICY NUMBER

GROUP NUMBER | NAME OF PERSON INSURED | SOCIAL SECURITY NUMBER

ELIGIBILITY PHONE NUMBER | COPAY

WEIGHT _____ HEIGHT _____ BMI _____

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What is the reason for your visit today? (Check all applicable procedures below)

Nose & Face
- ☐ Primary Rhinoplasty
- ☐ Revision Rhinoplasty
- ☐ Brow Lift
- ☐ Facelift
- ☐ Neck Lift
- ☐ Eyelid Surgery
- ☐ Facial Implants
- ☐ Chin Augmentation
- ☐ Lip Augmentation
- ☐ Lip Suspension
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____

Breast & Body
- ☐ Breast Augmentation
- ☐ Breast Augmentation with Breast Lift
- ☐ Breast Reduction
- ☐ Capsulectomy
- ☐ Mommy Makeover
- ☐ Abdominoplasty
- ☐ Post-Bariatric Body Lift
- ☐ Brachioplasty (Arm Tuck)
- ☐ Liposuction
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____

MediSpa
- ☐ Botox®
- ☐ Restylane®
- ☐ Perlane®
- ☐ Juvéderm®
- ☐ Radiesse®
- ☐ Enzyme Peel
- ☐ Laser Hair Removal
- ☐ Skin Tightening Laser
- ☐ Photo Facial
- ☐ Pixel Treatment
- ☐ Cellulite Treatment
- ☐ Vein Treatment
- Other_____

Please describe why you are interested in having the procedure(s) listed above:_____

_____

Have you consulted with other physicians about procedure(s) indicated above: ☐ No ☐ Yes

If Yes, please describe your understanding of the procedure(s) _____

Is this procedure a revision from a previous surgery ☐ No ☐ Yes If yes, how many previous surgeries?_____

What is your "ideal time frame" for procedure(s) completion _____

Health Information

Personal Past History

Do you have any chronic medical problems? (Check all that apply)

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Seizures
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Asthma
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Psychiatric Diagnosis
- ☐ Bleeding Problems
- ☐ Liver Disease
- ☐ Gastric Reflux
- ☐ Other _____
- ☐ Cancer
- ☐ HIV or AIDS
- ☐ Stroke
- ☐ Hepatitis
- ☐ Emphysema
- ☐ Stomach Problems

Is there a personal or family history of anesthetic complications? ☐ No ☐ Yes

If yes, please explain _____

Family History

Do you have a family history of any medical problems? (Check all that apply) Please indicate family member.

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Seizures
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Asthma
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Psychiatric Diagnosis
- ☐ Bleeding Problems
- ☐ Liver Disease
- ☐ Gastric Reflux
- ☐ Other_____
- ☐ Cancer
- ☐ HIV or AIDS
- ☐ Stroke
- ☐ Hepatitis
- ☐ Emphysema
- ☐ Stomach Problems

HEALTH HISTORY

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Please list all prior operations	Date	List any complications
1.		
2.		
3.		
4.		
5.		
6.		

Please list all prior Hospitalizations	Date	List any complications
1.		
2.		
3.		
4.		
5.		

Medications

Please list ALL MEDICATIONS and/or dietary supplements (PLEASE PROVIDE A LIST IF YOU HAVE ONE) including:

(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil and St. John's Wort)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Allergies

Please list ALL ALLERGIES and describe reactions: (i.e. Shellfish, Latex, Penicillin, etc).

1. ALLERGY: _____ REACTION _____
2. ALLERGY: _____ REACTION _____
3. ALLERGY: _____ REACTION _____
4. ALLERGY: _____ REACTION _____
5. ALLERGY: _____ REACTION _____

Social History:

Have you ever used tobacco products? ☐ No ☐ Yes If yes, how long? _____ How many packs per day? _____

Which tobacco product(s) have you used? _____

If you are a former smoker, state the year you stopped: _____

Past or current use of Nicotine Gum, Patch, or any other type of stop-smoking aid: ☐ No ☐ Yes

If yes, please list: _____

Alcohol Consumption: ☐ Never (Do not consume alcohol) ☐ Rare (1-2 drinks a week) ☐ Moderate (7-10 drinks a week) ☐ Heavy (daily or more than 10 drinks a wk)

Did you ever drink heavily in the past? ☐ No ☐ Yes

Are you feeling hopeless about the present/future? ☐ No ☐ Yes

Do you currently have thoughts of harming yourself? ☐ No ☐ Yes

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Review of Systems

Please answer the following Yes or No questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

CARDIOVASCULAR
- High Blood Pressure ☐ Yes ☐ No
- Heart Attack ☐ Yes ☐ No
- Angina/Chest Pain ☐ Yes ☐ No
- Heart Bypass Surgery ☐ Yes ☐ No
- Pacemaker ☐ Yes ☐ No
- Heart Failure ☐ Yes ☐ No
- Irregular Heartbeat ☐ Yes ☐ No
- Heart Murmur ☐ Yes ☐ No
- Do you Exercise? ☐ Yes ☐ No
- Comments: _____

NEUROLOGICAL
- Stroke ☐ Yes ☐ No
- Seizures ☐ Yes ☐ No
- Fainting ☐ Yes ☐ No
- Dizziness ☐ Yes ☐ No
- Headache ☐ Yes ☐ No
- Double Vision ☐ Yes ☐ No

PSYCHIATIC
- Depression ☐ Yes ☐ No
- Anxiety ☐ Yes ☐ No
- Psychiatric Care ☐ Yes ☐ No
- Obsessive Compulsive Disorder ☐ Yes ☐ No

ENDOCRINE
- Diabetes ☐ Yes ☐ No
- Thyroid Disease ☐ Yes ☐ No
- Taken Steroids ☐ Yes ☐ No

HEMATOLOGIC/ONCOLOGIC/
- Bleeding Tendency ☐ Yes ☐ No
- Easy Bruising ☐ Yes ☐ No
- Anemia ☐ Yes ☐ No
- Sickle Cell Disease ☐ Yes ☐ No
- Blood clots in Legs ☐ Yes ☐ No
- Blood clots in Lungs ☐ Yes ☐ No
- Radiation Therapy ☐ Yes ☐ No

EYES
- Cataracts ☐ Yes ☐ No
- Glaucoma ☐ Yes ☐ No

SKIN
- Basal Cell Skin Cancer ☐ Yes ☐ No
- Melanoma ☐ Yes ☐ No
- Staph Infection ☐ Yes ☐ No

RESPIRATORY
- Abnormal Chest X-ray ☐ Yes ☐ No
- Asthma ☐ Yes ☐ No
- Bronchitis ☐ Yes ☐ No
- Emphysema ☐ Yes ☐ No
- Recent Chest Infection ☐ Yes ☐ No
- Shortness of Breath ☐ Yes ☐ No
- Shortness of Breath at Night ☐ Yes ☐ No
- Shortness of Breath on Exertion ☐ Yes ☐ No
- Cough ☐ Yes ☐ No
- Cough with Sputum ☐ Yes ☐ No
- Sleep Apnea ☐ Yes ☐ No
- — Use a C-PAP Machine ☐ Yes ☐ No

MUSCULOSKELETAL
- Sciatica ☐ Yes ☐ No
- Herniated disc ☐ Yes ☐ No
- Arthritis ☐ Yes ☐ No
- Rheumatoid ☐ Yes ☐ No
- Neck, Back, Arm, Leg Problems ☐ Yes ☐ No

INFECTIOUS GASTROINTESTINAL
- Jaundice ☐ Yes ☐ No
- Hepatitis ☐ Yes ☐ No
- Ulcers ☐ Yes ☐ No
- Hiatal Hernia ☐ Yes ☐ No
- Heartburn ☐ Yes ☐ No

URINARY/REPRODUCTIVE
- Kidney Disease ☐ Yes ☐ No
- Urinary Disease ☐ Yes ☐ No
- Dialysis ☐ Yes ☐ No
- If female, could you be pregnant? ☐ Yes ☐ No
- Number of live births _____
- Number of pregnancies _____
- Date of last mammogram _____
- Date of last menses (period) _____

Assignment and Release

I, the undersigned, have insurance coverage with _____ and assign directly to Frederick Eko, M.D., Inc. DBA Eko Plastic Surgery, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. If the nature of the disability be such that it is not covered by insurance, I will be responsible to the doctor for payment of the entire bill. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

▶ _____ SIGNATURE OF INSURED/GUARDIAN ▶ _____ DATE

▶ _____ PATIENT'S SIGNATURE ▶ _____ DATE

Submit