newvue
PLASTIC SURGERY | SKIN CARE

NEW PATIENT INFORMATION

Today's Date: _____ □ Male □ Female Date of Birth (*mm/dd/yyyy*): _____ Age: _____

Name: _____
(first) (middle initial) (last)

Address: _____
(street) (city) (state) (zip)

Primary Phone #: _____ Email Address: _____
(we use email frequently to communicate appointment information and do NOT send solicited material)

How may we contact you? □ Phone □ Voice Message □ Email □ Postal Mail □ Text

SSN #: _____ Employer: _____ Occupation: _____

Primary Concern(s) | Reason for your visit: _____

Name of referring physician / individual (if applicable): _____ May we thank them? □ Yes □ No

Relationship/Marital Status: □ Single □ Married | Spouse name: _____ Phone #: _____
□ Also, your emergency contact?

Other relationship status (if you would like us to include it in your file): _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

INSURANCE

Primary Insurance Company: _____ ID#: _____ Group #: _____

Insured Name: _____ DOB: _____ SS #: _____

Secondary Insurance Company: _____ ID#: _____ Group #: _____

Insured Name: _____ DOB: _____ SS #: _____

I hereby authorize payment of any surgical and/or medical benefits directly to the physician for services. I also agree to pay all charges that exceed or are not covered by insurance and authorize release of information to the insurance company. I also authorize the physician to disclose information to those individuals qualified for the purpose of medical quality assurance and peer review.

Patient Signature: _____ Date: _____ Time: _____

Breast Cancer Patients:
(Please circle if known)

Right / Left sided breast cancer | Ductal / Lobular | Invasive / In Situ | Stage: _____ | Grade: _____
ER: + / - | PR: + / - | Her-2 Neu: + / - | KI 67: + / -

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HISTORY & PHYSICAL

Check / Circle all that apply

Neurological
- □ Stroke / TIA
- □ Neuromuscular disorder / spasm
- □ Psychiatric care
- □ Chronic Pain
- □ Migraines / headaches
- □ Anxiety / depression
- □ Seizures / paralysis

HEENT
- □ Hyperthyroid (High thyroid) / Hypothyroid (low thyroid)
- □ Contacts / Glasses
- □ Hearing Aids
- □ Dentures / Permanent Retainer / Veneers
- □ [Recent] Frequent Cold / Sinus congestion

Cardiac
- □ Mitral valve prolapse
- □ Hypertension (High blood pressure)
- □ Heart Palpitations
- □ Heart Murmur
- □ Pacemaker
- □ History of Abnormal EKG
- □ Heart disease
- □ Anemia
- □ Bleeding tendencies

Respiratory
- □ Smoker/Tobacco use
- □ Shortness of breath / Difficulty breathing
- □ Tuberculosis (TB)
- □ Asthma
- □ Inhaler Use
- □ Sleep apnea / snoring
- □ CPAP use

GI/GU
- □ Diarrhea
- □ Constipation
- □ GERD / Reflux
- □ Dark/chocolate colored urine
- □ [Recent] Nausea / Vomiting / Fever / Chills

Skin/Extremities
- □ Muscle disorder / spasm
- □ Numbness / tingling / cramping in hands or feet
- □ Rashes
- □ Wounds

Other
- □ Problem with Anesthesia (You OR Family)
- □ Malignant Hyperthermia (You OR Family)
- □ Cancer (of _____)
- □ Hepatitis / HIV (Type: _____)
- □ Diabetes (Type I / Type II)
- □ Herpes (cold sore / genital / shingles)
- □ Weight Increase / Decrease

Drug Allergies & Reactions: _____

_____

Latex Allergy? □ Yes □ No **Reaction**: _____

For our female patients: # of pregnancies: _____ # of births: _____ last mammogram: _____ bra size: _____

Current Medication(s), Supplements & dosage information:

_____

_____

_____

Previous surgeries, hospitalizations/illnesses & date: _____

_____

_____

Significant family history: _____

_____

VITAL SIGNS

BP: _____ HR: _____ RR: _____ Temp: _____ O2 Sat: _____ Ht: _____ inches. Wt: _____ lbs.

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RISK FACTORS

Exercise/Activity Level: _____

Alcohol Consumption:
_____ I never consume alcoholic drinks
_____ I occasionally consume alcoholic drinks | approximately _____ drinks(s) per week / month
_____ I regularly consume alcoholic drinks | approximately _____ drinks(s) per week

Nicotine Use:
_____ I am NOT a smoker
_____ I no longer smoke regularly. I quit _____ weeks / months / years ago
_____ I currently smoke _____ a day

There is greater risk in smokers for bad scarring, hematoma formation, intraoperative bleeding, bleeding, poor or delayed healing, hair loss, sloughing of the skin (skin loss), infection, increased or prolonged bruising and hyperpigmentation.

Marijuana Use: (ie: smoking, vaping, edible)
_____ I am NOT a Marijuana user
_____ I occasionally use Marijuana | approximately _____ per week / month
_____ I regularly use Marijuana | approximately _____ times per week
_____ Other Recreational Drug Usage | Please specify drug _____ | approximately _____ times per week/ month

I hereby declare that the information I have provided on this form is a true and accurate record to the best of my knowledge.

Patient Signature: _____ Date: _____ Time: _____

AUTHORIZATION TO RELEASE INFORMATION

If requested, I, _____, authorize the following information to be shared with:
(Patient Name)

1) Name: _____ Phone: _____ Relationship: _____

2) Name: _____ Phone: _____ Relationship: _____

3) Name: _____ Phone: _____ Relationship: _____

□ NO ONE

□ ALL INFORMATION □ APPOINTMENT DATES/TIMES □ TEST RESULTS □ INSURANCE INFORMATION

□ OTHER: _____

Regarding the initialed items above, I understand that by signing this form only the person(s) designated above are allowed to obtain my information and they are only allowed to obtain information regarding the items that I have designated below. By initialing beside "ALL INFORMATION" I understand that the person(s) listed above will be granted access to obtain all of my medical and personal information that the office of Newvue Plastic Surgery has on file. I understand that this written authorization will remain in my permanent record and will not change at any time unless I issue a written consent to discontinue and/or change this authorization.

Patient Signature: _____ Date: _____ Time: _____

Reviewed / Witnessed by Signature: _____ Date: _____ Time: _____

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CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I, _____, whose signature appears below, authorize Newvue Plastic Surgery and its Affiliated Providers to view my external prescription history via our electronic health record system, eClinical Works.

I understand that prescription history from other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and authorized staff here, and it may include prescriptions dated back several years.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTAND THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS TO MY PRESCRIPTION HISTORY.

Patient Signature: _____ Date: _____ Time: _____

Please provide us with your preferred pharmacy information:

Pharmacy Name: _____ Pharmacy Phone #: _____

Pharmacy Address/Location: _____

PATIENT PHOTOGRAPH RELEASE FORM

I hereby grant permission for Newvue Plastic Surgery and its designated representatives to take and use any pre-operative or post-operative photographs of myself for purposes of medical record, research, education and medical publications as well as advertising. I understand that no form of compensation shall become payable to me for the use of photographs. I further understand no names, birth dates or private information will be disclosed.

Patient Name (please print): _____

Patient Signature: _____ Date: _____ Time: _____

***If patient is under 18 years of age or requires signature of a legal guardian:*

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____ Time: _____

ACKNOWLEDGMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed that I have rights to privacy regarding my protected health information, and I have been given the opportunity to review this office's Notice of Privacy Practices as required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Provide and coordinate treatment among health care providers who may be involved in my care
2. Obtain payment from third-party payers for my health care services
3. Conduct normal health care operations

Patient Name (please print): _____

Patient Signature: _____ Date: _____ Time: _____

***If patient is under 18 years of age or requires signature of a legal guardian:*

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____ Time: _____