GARTNER
PLASTIC SURGERY
AND LASER CENTER

PATIENT DEMOGRAPHICS

Patient's Name: _____

Patient's Address: _____

City: _____ **State:**_____ **Zip:**_____

Home Phone #: (_____)_____ **Cell #:**(_____)_____

Date of Birth: _____/_____/_____ **Age:** _____ [ ]**Male** [ ]**Female**

Social Security #: _____-_____-_____ **Email:** _____

Marital Status: [ ] Single [ ] Married [ ] Widow **Primary Language:** _____

Occupation: _____ [ ] Full Time [ ] Part-Time [ ] Retired

Address: _____**Phone #** (_____)_____

Who referred you to our facility?

[ ] Friend / Relative/ Previous Patient: _____

[ ] Physician _____

[ ] Google [ ] DocFind [ ] Realself [ ] Instagram [ ] Facebook [ ] Twitter [ ] Snapchat [ ] Other: _____

Follow us on @GartnerPlasticSurgery @GartnerPlasticSUrgery @drgartner

What are you consulting the doctor for today? _____

Primary Care Physician: _____ **Phone #** (_____)_____

Pharmacy Name: _____ **Pharmacy Phone#** (_____)_____

By signing, I confirm that the information that I have provided is accurate to the best of my knowledge.

_____ **Date** _____/_____/_____

(Patient or Guardian's Signature)

Name	Address	DOB AGE SEX

Phone	Allergies to Meds:
Home:_____ Work:_____ Cell:_____ Other:_____	

HT: WT: Current Bra Size	Current Meds:	
Desired Breast Size	Medical History:	
Pregnancies		
Last Mammogram		
Family Breast Cancer		

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Patient History

Name: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Procedure / Reason for Visit:

_____

_____

Are you currently under the care of, or do you have an Internist / Family Physician/ Primary Care?

Name of Physician: _____ Phone # _____

Address: _____

Allergies

- ☐ Adhesive Tape Reaction: _____
- ☐ Codeine Reaction: _____
- ☐ Cortisone Reaction: _____
- ☐ Iodine Reaction: _____
- ☐ Latex Reaction: _____
- ☐ Penicillin Reaction: _____
- ☐ Shellfish Reaction: _____

Type (Other)	Reaction

Medications

Drug	Dose	Frequency	Prescribed By

Past Medical History

- ☐ No History
- ☐ Anxiety
- ☐ Asthma
- ☐ Abnormal Chest Xray
- ☐ Ankle Swelling
- ☐ Arthritis
- ☐ Back Injury
- ☐ Bleeding Disorder
- ☐ Blood Clots in Legs
- ☐ Breast Cancer
- ☐ Broken Bones
- ☐ Bruising
- ☐ Cancer
- ☐ Chest Pain / Tightness
- ☐ Chronic Cough
- ☐ Confusion
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Eczema
- ☐ Emphysema
- ☐ Facial Injury
- ☐ Fainting
- ☐ Head or Neck Injury
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Hives
- ☐ Irregular Heartbeat
- ☐ Joint Replacement
- ☐ Kidney Stones
- ☐ Leg Pain
- ☐ Lupus
- ☐ Migraine
- ☐ Mitral Valve Prolapse
- ☐ Muscle Weakness
- ☐ Numbness of Arms or Legs
- ☐ Pacemaker
- ☐ Positive TB Test
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Skin Cancer
- ☐ Skin Disease
- ☐ Stroke / TIA
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Urinary Tract Infection
- ☐ Xray Therapy
- ☐ Other

If yes, please explain:

_____

_____

_____

Surgical History

Surgery / Hospitalization	Date	Notes

Anesthesia Complications: _____

Family History

- ☐ No History
- ☐ Abnormal Bleeding
- ☐ Abnormal Clotting
- ☐ Adopted
- ☐ Anesthesia Problems
- ☐ Autoimmune Disorders
- ☐ Brain Tumor
- ☐ Breast Cancer
- ☐ Cleft Lip
- ☐ Cleft Palate
- ☐ Diabetes
- ☐ Drug Allergies
- ☐ Endocrine disease
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ Malignant Hyperthermia
- ☐ Other Cancer
- ☐ Ovarian Cancer
- ☐ Prostate Cancer
- ☐ Skin Cancer
- ☐ Skin Disease
- ☐ Substance Abuse
- ☐ Von Willebrand

If yes, specify family member afflicted:

_____

_____

_____

Social History

Alcohol:

- ☐ Denies use
- ☐ Social use
- ☐ Daily use
- ☐ History of alcoholism

Illegal Drugs:

- ☐ Denies use
- ☐ Admits use
- ☐ History of drug abuse

Tobacco:

- ☐ Non-user
- ☐ Former Smoker
  - How long did you smoke? _____
  - When did you quit? _____
- ☐ Current Smoker
- ☐ Current Smokeless User

STD:

- ☐ Denies History
- ☐ Admits History

Patient Ability to Heal

☐ Does your skin appear fragile, burns easily?	Yes	No
☐ Do you form a thick or raised scar from a cut or burn?	Yes	No
☐ Do you wax or use depilatories on your face?	Yes	No
☐ Do you ever get cold sores?	Yes	No

All information provided above is accurate and complete to the best of my knowledge.

Patient Signature: _____ Date: _____

Michael C. Gartner, DO / Tri-State Surgery Center

Patient Disclosure Consent

HIPAA privacy rules give individuals the right to request a restriction of uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that communications be made via alternative means such as sending information to the individuals' place of employment instead of their home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER *(check all that apply)*

☐ Home telephone # _____

- ☐ OK to leave a detailed message.
- ☐ Leave a message with a callback number ONLY.

☐ Work telephone # _____

- ☐ OK to leave a detailed message.
- ☐ Leave a message with a callback number ONLY.

☐ Cell Phone # _____

- ☐ OK to leave a message with detailed information.
- ☐ A message with a callback number ONLY.

WOULD YOU LIKE TO BE NOTIFIED OF ANY SPECIALS OR PROMOTIONS?

- ☐ **E-MAIL**
- ☐ **TEXT**

☐ **Emergency Contact Person :** _____

Relationship _____

Phone # _____

- ☐ **OK to leave a message with detailed information.**
- ☐ **Leave a message with a callback number ONLY.**

☐ Alternate telephone # _____

PRIVACY RULES REQUIRE US TO TAKE REASONABLE STEPS TO LIMIT THE USE OR DISCLOSURE OF YOUR INFORMATION TO THE MINIMUM NECESSARY TO ACCOMPLISH THE INTENDED PURPOSE USES, AND DISCLOSURES ARE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY.

Signature Print Name Date

Summary of Notice of Privacy Practices

This summary is provided to assist you in understanding the Notice of Privacy Practices

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your right as a patient and our common practices in dealing with patient health information.

Uses and Disclosures of Health Information

We will use and disclose information in order to treat or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for services or to allow insurance companies to process insurance claims for services rendered to you by us or health care providers. Finally, we will disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of students.

Uses and Disclosures based on Your Authorization

Except as states in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without you written authorization.

Uses and Authorizations Not Requiring Your Authorization

In the following circumstances, we may disclose your health information without written authorization:

- ✓ **To family members or close friends who are involved in your health care**
- ✓ **To certain limited research purposes for purposes of public health safety**
- ✓ **To government agencies for purposes of their audits, investigations, and other oversight activities**
- ✓ **To government authorities to prevent child abuse or domestic violence**
- ✓ **To the FDA to report product defects or incidents**
- ✓ **To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders**
- ✓ **When required by court orders, search warrants, subpoenas and as otherwise required by law.**

Patient Rights

As our patients, you have the following rights:

- ✓ **To have access to/and or a copy of your health information**
- ✓ **To receive an accounting of certain disclosures we have made your health information**
- ✓ **To request restrictions as to how your health information is used or disclosed**
- ✓ **To request that we communicate with you in confidence**
- ✓ **To request that we amend your health information**
- ✓ **To request notice of our privacy practices**

If you have a question, concern or complaint regarding our privacy practices, please refer to the Notice of Privacy Practices for the person or persons whom you may contact.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Privacy Practices and that I have read (or have had the opportunity to read if I so choose) and understand the notice.

_____ _____

Patient Name (Please Print) ***Parent of Authorized Representative (If Applicable)***

_____ _____

Signature ***Date***