



PATIENT NAME _____ DATE OF BIRTH _____ AGE _____ M F

ADDRESS _____
STREET _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

SSN # _____ EMPLOYER _____

EMAIL ADDRESS: _____

WOULD YOU LIKE TO RECEIVE INFORMATION ON ACTIVITIES AND EVENTS THROUGH EMAIL? YES NO

MARITAL STATUS: S M D W HEIGHT _____ WEIGHT _____

BILL TO : IF SAME AS ABOVE CHECK HERE

RESPONSIBLE PERSON NAME _____ RELATIONSHIP _____

ADDRESS _____ TELEPHONE _____

CITY, STATE, ZIP _____ SSN# _____

EMPLOYER _____ TELEPHONE _____

PRIMARY INSURANCE _____

POLICY # _____ GROUP _____ PLAN _____

SECONDARY INSURANCE _____

POLICY # _____ GROUP _____ PLAN _____

MEDICAL INFORMATION

FOR YOUR BENEFIT IT IS NECESSARY THAT YOU ANSWER THESE QUESTIONS AS ACCURATELY AS POSSIBLE SO THAT WE CAN DETERMINE YOUR PHYSICAL CONDITION BEFORE UNDERGOING SURGERY.

PRIMARY PHYSICIAN'S NAME _____

REFERRING PHYSICIAN _____

REASON FOR SEEING THE DOCTOR _____

MEDICAL HISTORY

PAST SURGICAL PROCEDURES WITH DATES _____

CURRENT MEDICATIONS _____

ALLERGIES _____

(PLEASE GO TO NEXT PAGE)



DO YOU HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
HEART DISEASE	___	___	LIVER DISEASE	___	___	ASTHMA	___	___
HIGH BLOOD PRESSURE	___	___	DRY EYE SYNDROME	___	___	GLAUCOMA	___	___
SHORTNESS OF BREATH	___	___	HEPATITIS	___	___	NERVOUS CONDITION	___	___
CHEST PAIN	___	___	CANCER	___	___	DEPRESSION	___	___
DIABETES	___	___	ANEMIA	___	___	COLD SORES	___	___
SEIZURE DISORDER	___	___	EASY BRUISING	___	___			
THYROID DISEASE	___	___	BLEEDING DISORDER	___	___			
KIDNEY DISEASE	___	___	AIDS/HIV	___	___			

DO YOU TAKE :

	YES	NO		YES	NO		YES	NO
HEART MEDICATION	___	___	BLOOD THINNERS	___	___	GARLIC	___	___
HIGH BLOOD PRESSURE MEDICATION	___	___	ASPIRIN	___	___	GINSENG	___	___
DIURETICS (WATER PILLS)	___	___	GINGER	___	___	GINKGO	___	___
ANTI-INFLAMMATORIES	___	___	SAINT JOHN'S WORT	___	___	STERIODS	___	___
			ECHINACEA	___	___	TESTOSTERONE	___	___

DO YOU SMOKE? YES NO IF YES, HOW MUCH? _____

DO YOU DRINK ALCOHOL? YES NO IF YES, HOW OFTEN? _____

HAVE YOU EVER HAD A PROBLEM WITH DRUGS OR ALCOHOL NOW OR IN THE PAST? YES NO

PLEASE LIST ANY ADDITIONAL MEDICAL PROBLEMS THAT HAVE NOT BEEN ADDRESSED :

ADDITIONAL INFORMATION:

HOW DID YOU HEAR ABOUT OUR PRACTICE?

___ MY PHYSICIAN _____	___ MY INSURANCE PROVIDER _____
___ A FRIEND/FAMILY MEMBER _____	___ A SEMINAR GIVEN BY THE PRACTICE _____
___ ANOTHER PATIENT _____	___ AN ARTICLE OR ADVERTISEMENT _____
___ INTERNET SEARCH _____	___ THE YELLOW PAGES _____
___ OTHER _____	___ BREASTIMPLANTS411.COM _____

PLEASE CHECK ANY OF THE FOLLOWING PLASTIC SURGERY ISSUES THAT ARE OF INTEREST TO YOU:

___ BOTOX INJECTIONS	___ FACELIFT/BROWLIFT	___ ACNE
___ BREAST ENHANCEMENT	___ EYELID SURGERY	___ BIRTHMARKS
___ BREAST REDUCTION	___ RHINOPLASTY (NOSE JOB)	___ SKIN CARE PRODUCTS
___ BREAST LIFT	___ LASER RESURFACING	___ SKIN CARE ADVICE
___ ABDOMINOPLASTY (TUMMY TUCK)	___ SKIN REJUVENATION	___ SCAR MANAGEMENT
___ BODY CONTOURING	___ CHEMICAL PEELS	___ HAIR REMOVAL
___ LIPOSUCTION	___ MICRO-DERMABRASION	___ LASER TREATMENTS
___ THIGH LIFT	___ FACIAL FILLERS (FAT, COLLAGEN, OTHER)	___ SUNSCREEN ADVICE
___ OTOPLASTY (EAR PINNING)	___ LIVER/AGE SPOTS	___ OTHER _____



PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND CLAIM PAYMENT AUTHORIZATION

I HEREBY AUTHORIZE THE ABOVE PHYSICIAN(S) TO RELEASE ANY INFORMATION REGARDING SERVICES RENDERED BY HIM AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO FILE INSURANCE.

_____ X _____
DATE PATIENT

I AGREE TO PRESENT ALL CLAIMS TO MY HEALTH INSURANCE CARRIER. I UNDERSTAND THAT I WILL REMAIN LIABLE FOR ALL PHYSICIAN'S CHARGES, AND IN THE EVENT OF PAST DUE ACCOUNTS, I UNDERSTAND THAT COLLECTION COSTS, COURT COSTS, AND REASONABLE ATTORNEY'S FEES WILL APPLY TO ALL PAST DUE ACCOUNTS. I HEREBY AUTHORIZE AND DIRECT PAYMENT CHECK(S) FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY THE ABOVE NAMED PHYSICIAN(S) TO BE MADE DIRECTLY TO HIM.

_____ X _____
DATE PATIENT

IN THE EVENT THAT OUR OFFICE NEEDS TO CONTACT YOU BY PHONE, PLEASE INDICATE BY CHECKING THE NUMBER(S) WHERE WE MAY CALL AND/OR LEAVE A MESSAGE.

HOME:	_____ OK TO CALL	_____ OK TO LEAVE MESSAGE	_____ DO NOT CALL
WORK:	_____ OK TO CALL	_____ OK TO LEAVE MESSAGE	_____ DO NOT CALL
CELL:	_____ OK TO CALL	_____ OK TO LEAVE MESSAGE	_____ DO NOT CALL

WHY YOUR PHYSICIAN RECOMMENDS MEDICAL PHOTOGRAPHS AS A FIRST STEP IN PLASTIC OR COSMETIC SURGERY:

- THEY PROVIDE AN ACCURATE RECORD OF YOUR APPEARANCE BEFORE SURGERY
- SHOULD YOU OR YOUR PHYSICIAN DECIDE ON FURTHER CONSULTATIONS, PHOTOGRAPHS ADD SCOPE AND CLARITY TO YOUR DISCUSSIONS
- THEY ASSIST YOUR PHYSICIAN IN PLANNING YOUR OPERATION. ACCURATE MEDICAL PHOTOGRAPHS ACT AS AN "INSTRUMENT" THE DOCTOR CAN WORK WITH USING OVERLAYS, DRAWINGS AND WRITTEN INDICATIONS FOR GUIDANCE.
- IN THE OPERATING ROOM, YOUR PHOTOGRAPHS BECOME AN INTEGRAL PART OF THE SURGICAL PROCEDURE, SERVING AS AN IMMEDIATE AND RELIABLE REFERENCE DURING EVERY STEP.
- MEDICAL PHOTOGRAPHS ARE A RELIABLE VISUAL DOCUMENT TO WHICH YOU AND YOUR SURGEON CAN REFER AT ANY TIME.

CONSENT TO TAKE AND RELEASE OF PHOTOGRAPHS

I HEREBY AUTHORIZE JAMES R. BRUNO, DMD, MD AND C. COLEMAN BROWN, MD, LLC TO TAKE AND USE PRE-OPERATIVE, INTRA-OPERATIVE, AND POST-OPERATIVE PHOTOGRAPHS FOR PROFESSIONAL MEDICAL PURPOSES DEEMED APPROPRIATE. THIS MAY INCLUDE, BUT IS NOT LIMITED TO, SHOWING THESE IMAGES FOR PURPOSES OF MEDICAL AND PATIENT EDUCATION.

I UNDERSTAND THAT I WILL NOT BE ENTITLED TO MONETARY PAYMENT OR ANY OTHER CONSIDERATION AS A RESULT OF ANY USE OF THESE IMAGES.

_____ X _____
DATE PATIENT

THANK YOU FOR VISITING THE PRACTICE OF DRs. BRUNO AND BROWN.