NCPS

NORTHERN CENTER FOR PLASTIC SURGERY

Patient Name:_____ Date:_____

Address:_____ _____ _____
(Street) *(City)* *(State)* *(zip code)*

Would you like to be part of our mailing list? Yes/No
(Includes invites to NCPS events and special promotions) E-mail:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Soc. Sec.#:_____ Date of Birth:_____ Age:_____ Sex:_____ Marital Status_____

Employer:_____ Referred By:_____

Name of Referring Physician:_____ Phone #_____

Name of Family Physician:_____ Phone #_____

Pharmacy:_____ Phone #_____

Primary Insurance Information

Name of Insured:_____ DOB:_____ Soc. Sec.#:_____

Name of Insurance: _____ Phone:_____

Mailing Address:_____

Policy #:_____ Group #:_____

Relationship to patient:_____

Secondary Insurance Information

Name of Insured:_____ DOB:_____ Soc. Sec.#:_____

Name of Insurance: _____ Phone:_____

Mailing Address:_____

Policy #:_____ Group #:_____

Relationship to patient:_____

I hereby authorize Aaron Capuano, MD and his representatives to release any information acquired in the course of medical examination, surgery/treatment for insurance claim filing. Photocopy of this signed authorization shall be considered as effective and valid as the original.

SIGNATURE:_____ Date:_____

Patient Medical Background Information

Reason for your visit:

Medical History:

History of Depression _____ If yes, when and what treatment:_____

Surgical History:	Name of Surgeon	Date of Surgery

Drug Reactions / Allergies / Latex Sensitivity

Some patients cannot take certain medications such as penicillin because of allergic reactions. Other patients experience reactions such as nausea / vomiting from narcotic pain medications (Codeine, Morphine, Demerol, Vicodin, Percocet, etc.). Please list below regarding any known drug allergies or reactions, or sensitivities.

Please list any medications you are allergic to:

1._____ 2._____

3._____ 4._____

____I do not have known drug allergies, drug reactions, or latex sensitivity.

Have you had any issues with anesthesia given during dental procedures? _____

If yes, please explain:_____

Prescription Medications

Please list all prescription medications you currently take:

1._____ 2._____

3._____ 4._____

_____I am not currently taking any prescription medications.

Non-Prescription Medications / Dietary Supplements / Vitamins / "Herbs" / Minerals

Many patients take non-prescription medications such as aspirin, anti-inflammatories (Advil, Motrin, Alleve) and other preparations that can be purchased without a prescription (dietary supplements, vitamins, "herbs", and minerals). Many of these can have profound effects on increased risk of bleeding during and after surgery or react with prescription medications. If you currently take items in this category, please list below. Please discontinue taking all non-prescription medications, dietary supplements, vitamins, herbs, and minerals for a minimum of 10 days before and after surgery.

1._____ 2._____

3._____ 4._____

_____I am not currently taking non-prescription medications, dietary supplements, vitamins, herbs, or minerals.

Smoking, Second-Hand Smoke Exposure, Nicotine Products (Patch, Gum, Nasal Spray)-

Patients who are currently smoking, use tobacco products, or nicotine products (patch, gum, or nasal spray) are at a greater risk for significant surgical complications of skin dying and delayed healing. Individuals exposed to second-hand smoke are also at potential risk for similar complications attributable to nicotine exposure. Additionally, smoking may have a significant negative effect on anesthesia and recovery from anesthesia, with coughing and possibly increased bleeding. Individuals who are not exposed to tobacco smoke or nicotine-containing products have a significantly lower risk of this type of complication. Please indicate your current status regarding these items below:

_____I am a non-smoker and do not use nicotine products. I understand the risk of second-hand smoke exposure causing surgical complications.

_____I am a smoker or use tobacco / nicotine products. I understand the risk of surgical complications due to smoking or use of nicotine products.

Dominant Hand: Right:_____ Left:_____
Pregnant?: Yes No
If yes, how many weeks?_____ When was the first day of your last menstrual cycle? _____

_____ I hereby grant permission to Dr. Capuano for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by the American Board of Plastic Surgery, Inc.

SIGNATURE:_____ Print Name:_____