1819 Lyndhurst Ave., Charlotte, NC 28203

(980) 949-6544

Patient Information Form

Patient Name: _____

Address: _____**City:** _____ **State:** ____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Date of Birth: _____ **Age:** _____ **Race:**_____

Gender: _____ **Social Security Number:** _____

Email Address: _____

Employer Name: _____ **Address:** _____

Occupation: _____ **Work Phone:** _____

How did you hear about our office?

- ☐**Google**
- ☐**Instagram**
- ☐**Friend:** _____
- ☐**Dr. Referral:** _____
- ☐**Patient Referral:** _____
- ☐**Other:** _____

What is the nature of your visit? _____

EMERGENCY CONTACT

Name: _____**Relationship:** ☐ **Spouse** ☐ **Parent/Guardian** ☐ **Other:** _____

Phone:_____

PHARMACY INFORMATION

Name: _____

Address: _____City: _____ State: _____Zip:_____

INSURANCE INFORMATION

Insurance Company: _____

Member ID: _____ Group #: _____

Provider Services Phone Number: _____

I, _____, have insurance coverage and assign 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. 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

SECTION 1: Surgery and Anesthesia History

1. **Have you ever had surgery? ☐ No ☐ Yes, please describe:**
   _____
   _____
2. **Do you have a blood relative who had anesthesia complication of any kind? ☐ No ☐ Yes, please describe:**
   _____
   _____

SECTION II: Specific Medical History

1. **Are you pregnant? ☐ No ☐ Yes**
2. **Height: _____ Weight: _____**

Have you or do you still have:

Asthma NO YES _____

Emphysema NO YES _____

High Blood Pressure NO YES _____

Heart Trouble NO YES _____

Hepatitis or Liver Trouble NO YES _____

Kidney Trouble NO YES _____

Diabetes NO YES _____

Epilepsy or Seizures NO YES _____

Stroke NO YES _____

Problem Scarring NO YES _____

Have you been advised or had psychiatric care? NO YES _____

Others Not Listed: _____

SECTION III: Social History

1. **Do you smoke? NO YES, frequency: _____**
2. **Do you drink? NO YES, frequency: _____**
3. **Do you have children? NO YES, how many? _____**

SECTION IV: Family History

Have you had any of the following: **DESCRIPTION**

1. **Cancer** **NO YES** _____
2. **Bleeding Tendency** **NO YES** _____
3. **Leukemia** **NO YES** _____
4. **Heart Disease** **NO YES** _____
5. **High Blood Pressure** **NO YES** _____
6. **Repeated Infections** **NO YES** _____
7. **Chronic Lung Disease** **NO YES** _____
8. **Tuberculosis** **NO YES** _____
9. **Asthma** **NO YES** _____
10. **Severe Allergies** **NO YES** _____
11. **Kidney Disease** **NO YES** _____
12. **Arthritis** **NO YES** _____
13. **Mental Illness** **NO YES** _____
14. **Convulsions or Fits** **NO YES** _____
15. **Migraine Headaches** **NO YES** _____
16. **Diabetes** **NO YES** _____
17. **Gout** **NO YES** _____
18. **Thyroid Trouble** **NO YES** _____
19. **Obesity** **NO YES** _____

Section V: Medications

Are you taking any medications, vitamins, or herbal supplement? NO YES, please list:

_____

_____

Section VI: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? NO YES, please list:

_____

_____

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ **Date:** _____

DILWORTH
FACIAL PLASTIC SURGERY
ANDREA GARCIA, MD. JOSH SUROWITZ, MD.

1819 Lyndhurst Ave.

Charlotte, NC 28203

(980) 949-6544

Consent to Communicate

Patient Name: _____

Please mark the ways that you consent to us communicating with you:

METHOD	OK to LEAVE VOICEMAIL	OK to LEAVE MESSAGE WITH ANOTHER PERSON	PREFERRED CONTACT METHOD
☐ Call Work Phone	☐YES ☐NO	☐YES ☐NO	☐
☐ Call Cell Phone	☐YES ☐NO	☐YES ☐NO	☐
☐ Call Home Phone	☐YES ☐NO	☐YES ☐NO	☐
☐ Send Email			☐
☐ Email Appointment Reminders			
☐Email Medical Information			
☐Email Office Specials			
☐ Send Regular Mail			☐
☐ Send Text Message			☐
☐Text Appointment Reminders			
☐Text Office Specials			

If it is OK to leave a message with another person, please list:

NAME	DOB	RELATIONSHIP	OK to RELEASE RESULTS
			☐YES ☐NO
			☐YES ☐NO

Signature: _____ Date: _____