

CRUISE PLASTIC SURGERY

Patient Information

I would like to be addressed as: _____
(Preferred Name/Nickname)

Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? No Yes E-mail _____

Contact Restrictions: _____ Drivers License # (include State) _____

Age ____ Birthdate _____ Sex Female Male

Marital Status Single Married to: _____

Children Yes No Ages: _____

Occupation _____ Work Phone _____

May we call you at work? Yes No

Emergency Contact
(f we cannot get in touch with you. We will contact this person)
Name _____ Relationship _____
Phone _____

Procedure Information

What is your primary area of concern today?

What procedure(s) are you interested in? _____

How long have you been thinking about this? _____

Has anything happened recently to stimulate your interest in having this done? _____

What are your goals from the surgery? _____

Why did you select Dr. Cruise as a candidate to perform this surgery? _____

Have you had other consultations? Yes No _____ Dr. _____ Dr. _____

When are you thinking about having this done? ASAP 1 month 2-3 months 3 > months

Secondary Areas of Concern/Future Procedures

Face/Neck

- Upper Eyes
- Lower Eyes
- Cheeks
- Nose
- Chin
- Neck
- Loose Skin/Jowling

Body

- Abdomen
- Breasts
- Upper Back
- Lower Back
- Thighs

Other

- Ears
- Lips
- Fine Lines/Wrinkles
- _____
- _____
- _____

Patient's Name _____
First Middle Last
 Age _____ Birthdate _____ Height _____ Weight _____ Gender Female Male

Purpose of Visit: _____

Previous Cosmetic and General Surgeries

Surgery	Date	Surgeon

Health Problems Past & Present: (mark all that apply)

- Diabetes
- Easy Bruising
- Cancer
- Bleeding/Clotting Problems
- Bleeding Tendency or Disorder
- Glaucoma or Eye Problems
- Dry Eye
- Abdominal Hernia
- Liver Problems
- Problem Constipation
- Breast Patients Only – Family History of Breast Cancer Yes No
- High Blood Pressure
- Lung/Breathing Problems
- Shortness of Breath
- Chest Pain
- Asthma
- Seizures or Convulsions or Fainting Spells
- Thyroid Problems
- Kidney or Renal Disease
- Positive Blood Test for HIV, AIDS, Hypotatis
- Use of Recreational Drugs Within Last 3 Months
- Heart Problems
- Heart Attack
- Palpitation or Irregular Pulse
- Stroke
- Alcohol Dependency
- Nervous Disorder
- Psychiatric / Depression
- Other:

Comments: _____

Is there anything else you think the doctor should know ? _____

Do you smoke? Yes No , How many packs a day? _____

Medications: (Include all Prescriptive, Over-The-Counter, Vitamins and Herbal medications taken regularly)

Have you ever taken: **Vicodin** Yes No **Darvocet** Yes No

Did you have any problems with either? _____

Do you have a pain medication that works well for you? _____

Drug or Latex Allergies: Yes No

Health Insurance _____

Policy# _____

Primary Physician _____

Phone _____

First and Last Name

Date of Last Physical: _____

If you will be using insurance to help pay for your procedure (or think you might) please fill out the following information:

Patient/Responsible Party Information

Responsible party _____ Birthdate _____

Relationship to patient Self Spouse Other: _____

Responsible party's home phone _____ Work phone _____

Address _____

How did you hear about us?

- | | | |
|---|--|--|
| <input type="checkbox"/> Internet | <input type="checkbox"/> From Previous Patient _____ | <input type="checkbox"/> Word of Mouth |
| <input type="checkbox"/> Gynecomastia.org | <input type="checkbox"/> Friend/Relative... _____ | <input type="checkbox"/> Walk In |
| <input type="checkbox"/> MakeMeHeal.com | <input type="checkbox"/> Plastic Surgery News Magazine | <input type="checkbox"/> Other _____ |

If you were referred by a specific person, may we thank them? Yes No

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

Signature _____ **Date** _____

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment.

I have been given the opportunity to review the uses and disclosures of protected health information about me for all of the purposes set out in our Notice.

Signature _____ **Date** _____