

# DONEN DAVIS PLASTIC SURGERY, LLC

Donen Davis, J.D, M.D.

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
(Last) (First) (Middle)

Home Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Cell/Pager: (\_\_\_\_) \_\_\_\_\_

E-mail address: \_\_\_\_\_ (if you would like to receive information from us)

SS#: \_\_\_\_\_ Gender: Male / Female Marital Status: (circle one) Single Married Divorced Widowed

Spouse Name: \_\_\_\_\_ Parent's Name (if patient is a minor): \_\_\_\_\_

Person to notify in an emergency: \_\_\_\_\_ / \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Name Relationship

Patient's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

## INSURANCE INFORMATION - Provide a copy of your insurance cards to the receptionist

**Primary** Insurance Company: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

ID# or Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Group Name/Employer: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

ID# or Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Group Name/Employer: \_\_\_\_\_

Worker's Compensation Patients: Date of Injury: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

## AUTHORIZATION TO RELEASE INFORMATION / ASSIGNMENT

I hereby authorize Donen Davis Plastic Surgery, LLC to furnish information to my Insurance carriers concerning my treatment, and I hereby assign to Dr. Donen Davis all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance. I authorize a photocopy of this assignment in lieu of the original when necessary.

\_\_\_\_\_  
Patient / Responsible Party Signature

\_\_\_\_\_  
Date

**MEDICAL HISTORY**

Reason for Visit Today: \_\_\_\_\_

Symptoms and for how long: \_\_\_\_\_

Have you been diagnosed and/or treated for: (Please answer each one)

Alcoholism	Yes	No	Hepatitis A,B,C	Yes	No
Anemia	Yes	No	Heart Attack	Yes	No
Arthritis	Yes	No	High Blood Pressure	Yes	No
Artificial Joint	Yes	No	HIV+	Yes	No
Asthma	Yes	No	Keloids or scarring	Yes	No
Anxiety Disorder	Yes	No	Kidney Disease	Yes	No
Blood Disorder	Yes	No	Liver Disease	Yes	No
Bowel Disorder	Yes	No	Lung Disease	Yes	No
Cancer	Yes	No	Prolonged Bleeding	Yes	No
Depression	Yes	No	Psychiatric Treatment	Yes	No
Diabetes	Yes	No	Radiation Treatment	Yes	No
Drug Addiction	Yes	No	Skin cancer	Yes	No
Allergies	Yes	No	Stroke	Yes	No
Heart Surgery	Yes	No	Thyroid Problems	Yes	No
Heart Disease	Yes	No	Ulcers	Yes	No

If you answered yes to any of the above, please explain: \_\_\_\_\_

Other current or previous medical conditions not listed above: \_\_\_\_\_

List previous operations with approximate dates: \_\_\_\_\_

Family history: \_\_\_\_\_

Please list all medications & supplements including dosages: \_\_\_\_\_

List any drug & food allergies: \_\_\_\_\_

Do you use tobacco products? **Yes** **No** If so, what type \_\_\_\_\_ and how often \_\_\_\_\_

Alcohol Use (circle one): **Socially** / **Rarely** / **Daily** / **Never** Do you use cocaine? **Yes** **No** Marijuana? **Yes** **No**

Patient's Height \_\_\_\_\_ Weight \_\_\_\_\_ Bra Size \_\_\_\_\_ Date of last mammogram: \_\_\_\_\_

**OFFICE USE ONLY**

Positive Findings: \_\_\_\_\_

Impression: \_\_\_\_\_

Donen Davis, J.D., M.D.: \_\_\_\_\_ Date: \_\_\_\_\_