Gregory O. Dick, MD, FACS
Plastic, Reconstructive & Cosmetic Surgery

PLEASE PRINT

PATIENT NAME _____ BIRTH DATE_____ M ❑ SEX F ❑
LAST NAME FIRST NAME MIDDLE

PATIENT'S ADDRESS _____
STREET CITY STATE ZIP CODE

HOME PHONE _____ CELL PHONE _____

PATIENT'S SS# _____ AGE _____ MARITAL STATUS: ❑ S ❑ M ❑ W ❑ D

E-MAIL _____

PATIENT EMPLOYER _____

EMPLOYER ADDRESS _____ EMPLOYER PHONE NO. _____

SPOUSE _____ BIRTHDATE _____ PHONE _____

SPOUSE'S EMPLOYER _____

EMERGENCY CONTACT

NAME _____

RELATIONSHIP TO PATIENT _____ PHONE_____

REFERRING PHYSICIAN _____ PHONE_____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ POLICY NO. _____ GROUP _____

POLICY HOLDER'S NAME _____ BIRTHDATE _____

SOCIAL SECURITY NUMBER _____ RELATIONSHP TO PATIENT _____

SECONDARY INSURANCE _____ POLICY NO. _____ GROUP _____

POLICY HOLDER'S NAME _____ BIRTHDATE _____

I VERIFY THAT ALL INFORMATION ON THIS FORM IS CORRECT.

_____ X_____
DATE PATIENT

AUTHORIZATION TO RELEASE MEDICAL INFORMATION, PATIENT RESPONSIBILITY AND CLAIM PAYMENT AUTHORIZATION

I AUTHORIZE GREGORY O. DICK, MD, FACS AND STAFF TO SUBMIT MEDICAL CLAIMS TO MY HEALTH INSURANCE CARRIER. I UNDERSTAND THAT I WILL BE LIABLE FOR ALL PHYSICIAN CHARGES, INCLUDING BUT NOT LIMITED TO, DEDUCTIBLES, CO-PAYS AND/OR CO-INSURANCE. I UNDERSTAND THAT ALL COLLECTION AND/OR ATTORNEY FEES ON PAST DUE ACCOUNTS WILL ULTIMATELY BE MY RESPONSIBILITY. I AUTHORIZE DIRECT PAYMENT FROM MY INSURANCE CARRIER FOR ALL SERVICES RENDERED BY GREGORY O. DICK, MD, FACS BE MADE DIRECTLY TO HIM.

_____ X_____
DATE PATIENT

(OVER) ➡

MEDICAL INFORMATION

PRIMARY PHYSICIAN'S NAME _____

ADDRESS _____

PHONE NUMBER _____

REASON FOR SEEING DR. DICK TODAY _____

PAST MEDICAL HISTORY

HAVE YOUR EVER HAD SURGERY? _____YES _____NO

TYPE	YEAR
_____	_____
_____	_____
_____	_____

DO YOU HAVE	YES	NO
Anemia	❑	❑
Asthma	❑	❑
Bleeding tendency	❑	❑
Broken Bones	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Diabetes	❑	❑
Easy bruising	❑	❑
Emphysema	❑	❑
Epilepsy	❑	❑
Heart Disease	❑	❑
Hepatitis	❑	❑
High Blood Pressure	❑	❑
Kidney Disease	❑	❑
Shortness of breath	❑	❑
TB	❑	❑
Thyroid Disease	❑	❑
ARE YOU ALLERGIC TO		
Penicillin	❑	❑
Novocaine	❑	❑
Latex	❑	❑

OTHER DRUG ALLERGIES, PLEASE LIST

_____

_____

LIST ALL MEDICATIONS YOU TAKE, INCLUDING SUPPLEMENTS

_____

_____

_____

_____

_____

DO YOU HAVE	YES	NO
AIDS/HIV	❑	❑
Depression	❑	❑
Dizzy Spells	❑	❑
Glaucoma	❑	❑
Herpes	❑	❑
Nervous Condition (Anxiety)	❑	❑
Ulcers	❑	❑
HAVE YOU EVER HAD		
Cold Sores	❑	❑
Rheumatic fever	❑	❑
DO YOU TAKE		
Aspirin	❑	❑
Blood thinner medication	❑	❑
Diuretics (water pills)	❑	❑
Heart medication	❑	❑
High blood pressure med.	❑	❑
Steroids	❑	❑
DO YOU DRINK ALCOHOL?	❑	❑
DO YOU SMOKE?	❑	❑
Have you smoked in the past?	❑	❑
FAMILY HISTORY		
Bleeding Disorder	❑	❑
Cancer	❑	❑
Diabetes	❑	❑
Heart Disease	❑	❑
High Blood Pressure	❑	❑

HAVE YOU, OR HAVE YOU EVER, HAD A PROBLEM WITH

ALCOHOL ❑ DRUGS ❑ NOW ❑ PAST ❑

PLEASE LIST ANY ADDITIONAL MEDICAL PROBLEMS

_____

_____

THANK YOU!