Gregory O. Di[illegible] MD, FACS
Plastic, Reconstructive & Cosmetic Surgery

PLEASE PRINT

Patient Name _____ Birth Date _____ Age _____ Sex M ❑ F ❑

Patient Address _____ Home Phone _____

_____

Father _____ Birth Date _____ SS# _____

Home Number (if different from patient) _____

Father's Address (Same as patient? ❑) _____

Father's Employer _____ Work Number _____

Employer's Address _____

Mother _____ Birth Date _____ SS# _____

Home Number (if different from patient) _____

Mother's Address (Same as patient? ❑) _____

Mother's Employer _____ Work Number _____

Employer's Address _____

Nearest Relative or Friend _____ Phone Number _____

Primary Insurance _____ Policy Number _____

Policy Holder's Name _____ Group Number _____

Claims Office Address _____

Claims Office Address _____ Policy Number _____

Policy Holder's Name _____ Group Number _____

Claims Office Address _____

DISCLOSURES

PARENT/GUARDIAN AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND CLAIM PAYMENT AUTHORIZATIONS

I HEREBY AUTHORIZE THE ABOVE PHYSICIAN TO RELEASE ANY INFORMATION REGARDING SERVICES RENDERED BY HIM AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO FILE INSURANCE.

_____ X _____

DATE PARENT OR GUARDIAN

"I AGREE TO PRESENT ALL CLAIMS TO MY HEALTH INSURANCE CARRIER. I UNDERSTAND THAT I WILL REMAIN LIABLE FOR ALL PHYSICIAN'S CHARGES, AND IN THE EVENT OF COLLECTION OF PAST DUE ACCOUNTS, I UNDERSTAND THAT COLLECTION COSTS, COURT COSTS, AND REASONABLE ATTORNEY'S FEES, WILL APPLY TO ALL PAST DUE ACCOUNTS." I HEREBY AUTHORIZE AND DIRECT PAYMENT CHECK(S) FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY THE ABOVE NAMED PHYSICIAN(S) TO BE MADE DIRECTLY TO HIM.

_____ X _____

DATE PARENT OR GUARDIAN

OVER ⬇

Primary Physician's name and address _____

_____

_____

For your benefit it is necessary that you answer these questions as accurately as possible so that we can determine your child's physical condition before undergoing surgery.

Complaint (Reason for seeing Dr. Dick) _____

_____

_____

PAST MEDICAL HISTORY

Has your child ever had surgery? ❑Yes ❑ No

Type of Surgery: _____ Year: _____

_____ _____

_____ _____

Does Your Child Have	YES	NO
Heart Disease	❑	❑
High Blood Pressure	❑	❑
Diabetes	❑	❑
Epilepsy	❑	❑
Thyroid Disease	❑	❑
Asthma	❑	❑
Kidney Disease	❑	❑
Broken Bones	❑	❑
Hepatitis	❑	❑
Cancer	❑	❑
Anemia	❑	❑
Easy bruising	❑	❑
TB (Tuberculosis)	❑	❑
Bronchitis	❑	❑
Poor Scarring	❑	❑
Shortness of breath	❑	❑

Is Your Child Allergic To:

Penicillin	❑	❑
Novocaine	❑	❑

Other Drug Allergies (please list)

_____

_____

List Any Drugs Your Child Takes:

_____

_____

_____

Does Your Child Have	YES	NO
Chest Pain	❑	❑
Dizzy Spells	❑	❑
Ulcers	❑	❑
Glaucoma	❑	❑
Nervous Condition	❑	❑
Depression	❑	❑
AIDS/HIV	❑	❑
Have Your Child Ever Had:		
Rheumatic fever	❑	❑
Hepatitis	❑	❑
Does Your Child:	❑	❑
Smoke	❑	❑
Have a past history of smoking	❑	❑
Drink alcohol	❑	❑
Are Your Child's Immunizations Up to Date?	❑	❑
Is There Family History Of:		
Cancer	❑	❑
Diabetes	❑	❑
Heart Disease	❑	❑
High Blood Pressure	❑	❑
Bleeding Disorder	❑	❑
Keloids	❑	❑

Please List Any Additional Medical Problems:

_____

_____

THANK YOU!