PATIENT INFORMATION FORM | LEONARD PLASTIC SURGERY

WELCOME TO OUR OFFICE
In order to serve you, we need the following information.
All information is strictly confidential.

Today's Date _____

Referred by _____

GENERAL INFORMATION

Patient's Name _____ Birthdate _____ Age _____

Social Security # _____ Sex _____ Marital Status _____ Spouse's Name _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Employer _____ Address _____

Occupation _____

In case of emergency call _____ Phone _____

If patient is a minor: _____

Responsible party _____ Social Security # _____

Address (if different from above) _____

Employer _____ Address _____

Occupation _____

Home Phone _____ Work Phone _____ Cell Phone _____

Relationship of responsible party to patient _____

Preferred Pharmacy _____ Location _____

INSURANCE

Primary Insurance Company _____

Insured Name _____

Insured's Birthdate _____

Secondary Insurance Company _____

Insured Name _____

Insured's Birthdate _____

ACCIDENT

Is this an on-the-job, automobile, or household accident? _____

Date of injury _____ If unable to work, date last worked _____

Where did injury occur? _____

How did injury occur? _____

Previous doctors seen for this injury _____

Name of Insured _____ Insurance Company _____

Policy or Claim # _____ Claim rep. _____

If applicable, attorney's name _____ Phone _____

Assignment & release: I hereby assign payment directly to Dann K. Leonard, MD and authorize release of any medical information necessary to secure payment of benefits, consent to medical photography and authorize release for medically related purposes. I am responsible for any charges not paid by my insurance. I am aware payment is due at the time of service unless prior arrangements were made with patient accounts. If it becomes necessary to enforce collections of any amount owed on this or subsequent visits the undersigned agrees to pay all costs and expenses, including attorney's fees. All accounts assigned to a collection agency will be charged an additional $100.00 collection fee.

Signature _____

Guardian Signature _____

Date _____

LEONARD
PLASTIC SURGERY

MEDICAL HISTORY FORM | LEONARD PLASTIC SURGERY

Name _____ Primary Physician _____

PRESENT PROBLEM:

Specific problem(s) for which you are seeing Dr. Leonard: _____

_____

Other physicians, including plastic surgeons, you have consulted about this problem (include dates):

_____

Allergies **Frequency and duration of use**

1) _____ Coffee/Tea _____/day for _____ yr.

2) _____ Tobacco _____/day for _____ yr.

3) _____ Alcohol _____/day for _____ yr.

All medications presently using and dosages/frequency

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Major Injuries/Illnesses **Year/Duration**

1) _____ _____

2) _____ _____

3) _____ _____

4) _____ _____

5) _____ _____

Previous Operations

1) _____ _____

2) _____ _____

3) _____ _____

4) _____ _____

5) _____ _____

Personal Medical History

Have you had any disorders of the following?

	Yes	No		Yes	No
Eyes & Ears	☐	☐	Nervous System	☐	☐
Nose/Sinus & Throat	☐	☐	Blood	☐	☐
Heart/Blood Vessels	☐	☐	Bones/Joints	☐	☐
Breasts	☐	☐	Urinary System	☐	☐
Lungs	☐	☐	Psychiatric	☐	☐
Gastrointestinal	☐	☐	Reproductive System	☐	☐
Liver	☐	☐	Other (Diabetes, etc)	☐	☐

Notes _____

_____

_____

_____

	Age	State of Health
Mother	____	_____
Father	____	_____
Brother(s)	____	_____
	____	_____
	____	_____
Sister(s)	____	_____
	____	_____
	____	_____
Children	____	_____
	____	_____
	____	_____
	____	_____

Family Medical History

Has any relative had:

	Yes	No
Tuberculosis	☐	☐
Cancer	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Diabetes	☐	☐
Kidney Disease	☐	☐
Asthma	☐	☐
Lung Disease	☐	☐
Blood Disorder	☐	☐
Epilepsy	☐	☐
Mental Disorder	☐	☐

Do you have high blood pressure? _____ Yes ☐ No ☐

Do you have shortness of breath with walking or when lying flat? _____ Yes ☐ No ☐

Have you ever had any chest pain? _____ Yes ☐ No ☐

Have you ever been found to have a heart murmur? _____ Yes ☐ No ☐

Have you ever had scarlet fever or rheumatic fever? _____ Yes ☐ No ☐

Do you have frequent infections or boils? _____ Yes ☐ No ☐

Have you ever taken steroid medications, cortisone, or ACTH? _____ Yes ☐ No ☐

Have you ever had a bad reaction to a local anesthetic? _____ Yes ☐ No ☐

Does your religion prohibit blood transfusions? _____ Yes ☐ No ☐

Do you have unusual bleeding from cuts, surgery, or tooth extractions? _____ Yes ☐ No ☐

Do you form large scars or keloids? _____ Yes ☐ No ☐

Have you ever had psychiatric care or been advised to see a psychiatrist? _____ Yes ☐ No ☐

Do you have or have you had any significant emotional problems? _____ Yes ☐ No ☐

Height _____ ft. _____ in. Weight _____ lbs. Weight change past year of _____ lbs. ☐ Loss ☐ Gain

Date of last menstrual period _____

Date of last physical exam: _____ Did it include EKG? ☐ Yes ☐ No

Chest X-Ray ☐ Yes ☐ No Examining Doctor _____

LEONARD
PLASTIC SURGERY

LEONARD PLASTIC SURGERY
Dann K. Leonard M.D.
Water Place, Suite 400
500 Liberty St. SE
Salem, OR 97301

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____ , have received a copy of
Patient Name

Dann K. Leonard, MD's Notice of Privacy Practices.

_____ _____
Signature of Patient Date