

# PARKWAY PLASTIC SURGERY

(904) 396-1186

Patient Information as of \_\_\_\_\_ (enter today's date)  
(Please Print Legibly & Fill In or Correct All Fields)

**Patient's Name** \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street & Apt # City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Any restrictions for contacting you?  No  Yes E-mail \_\_\_\_\_

Contact Drivers License # \_\_\_\_\_  
Restrictions: \_\_\_\_\_ (include State)

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Sex  Female  Male

Marital Status  Single  Married to: \_\_\_\_\_  Other: \_\_\_\_\_

**Patient's Employer** \_\_\_\_\_ Occupation \_\_\_\_\_

**Spouse's Employer** \_\_\_\_\_ Occupation \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street & Apt # City State Zip

**Primary Health Insurance Company** \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Relationship to Patient: Self Spouse Child Other

Insured: Name \_\_\_\_\_ DOB \_\_\_\_\_ Social Security # \_\_\_\_\_

**Secondary Health Insurance Company** \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Relationship to Patient: Self Spouse Child Other

Insured: Name \_\_\_\_\_ DOB \_\_\_\_\_ Social Security # \_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_ Office Phone # \_\_\_\_\_

**Referring Physician** \_\_\_\_\_ Office Phone # \_\_\_\_\_

I understand that services are rendered to me, not the insurance company. Therefore, payment for services are my responsibility. I authorize this office to release or receive any information necessary to expedite my insurance claim. I authorize this office to bill my insurance company directly for my services. I authorize payment directly to this practice for any insurance benefits otherwise payable to me. In the event that I receive payment from my insurance company, I agree to endorse any payment I receive over to my physician for which these fees are payable. I understand that I am directly and fully responsible to this practice for charges not covered by my insurance. I understand that such payments is not contingent on any settlement, judgement or insurance payment by which I eventually recover. I realize that if my insurance company fails to pay my balance in full, or there is no payment made within 60 days, it is my responsibility to pay my bill. I further understand that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collections. I understand there is a \$25 charge on all returned checks.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

5101-2 Gate Parkway , Jacksonville, FL 32256

Health Information as of \_\_\_\_\_ (enter today's date)  
 (Please Print Legibly & Fill In or Correct All Fields)

<b>Patient:</b>				
DOB	Age	Marital Status	Weight	lbs
What surgery are you considering?			Height	ft in

DO YOU NOW OR HAVE YOU EVER HAD..... ( You must circle an answer for each individual item)

Heart Trouble	Yes	No
Heart Attack	Yes	No
Heart Pain	Yes	No
Palpitation or Irregular Pulse	Yes	No
Extra Heart Beats	Yes	No
Stroke	Yes	No
Hypertension	Yes	No
Blood Pressure Abnormalities	Yes	No
Abnormal EKG	Yes	No
Rheumatic Fever	Yes	No
Dropsy or Heart Failure	Yes	No
Digitalis Treatment	Yes	No
Shortness of Breath	Yes	No
Chest Pain	Yes	No
Asthma	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Tuberculosis	Yes	No
Smokers Cough	Yes	No
Emphysema	Yes	No
Coughing or Spitting of Blood	Yes	No
Hay Fever	Yes	No
Major Allergies	Yes	No
Palsy or Paralysis	Yes	No
Nervous Breakdown	Yes	No
Nervous Disorder	Yes	No
Insomnia	Yes	No
Drug Habit	Yes	No
Self-Destructive Tendencies	Yes	No
Psychiatric Hospitalization or Care	Yes	No
Thyroid Problems	Yes	No
Kidney or Renal Disease	Yes	No
Heart murmur	Yes	No
Piercing other than the ears	Yes	No
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No
Missed or irregular last menstrual period	Yes	No
Family history of cancer, heart trouble, stroke	Yes	No

Glaucoma or Eye Problems	Yes	No
Visual Disturbances	Yes	No
Error in Refraction	Yes	No
Other Eye Problems	Yes	No
Hepatitis	Yes	No
Yellow Jaundice	Yes	No
Gallstones or Gallbladder Trouble	Yes	No
Cirrhosis of the Liver	Yes	No
Alcoholism or Drug Dependency	Yes	No
Esophageal Varices	Yes	No
Frequent Indigestion	Yes	No
Ulcers	Yes	No
Gastritis	Yes	No
Colitis	Yes	No
Problem Constipation	Yes	No
Vomiting Blood	Yes	No
Tarry or Bloody Bowel Movements	Yes	No
Hemorrhoids	Yes	No
Goiter or Thyroid Disorders	Yes	No
Diabetes	Yes	No
Skin Disorders	Yes	No
Arthritis	Yes	No
Fracture of Neck or Spine	Yes	No
Bleeding Tendency or Disorder	Yes	No
Abnormal Bleeding after Tooth Extraction	Yes	No
Airway Obstruction (Nasal)	Yes	No
Breast Cysts, Tumors, Abscesses	Yes	No
Nipple Discharge (Apart from Normal Lactation)	Yes	No
Kidney Disorder	Yes	No
Blood Transfusion	Yes	No
Seizures or convulsions or fainting spells	Yes	No
Black outs	Yes	No
Dentures, bridges, capped teeth or crowns	Yes	No
Loose teeth	Yes	No
Cosmetic bonding to teeth	Yes	No
Any family members with bleeding problems	Yes	No
Any family members with anesthesia problems	Yes	No

1. **Please list all present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. **Include over-the-counter medications.**

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2. Do you have an allergic reaction to any medication?  Yes  No Which? \_\_\_\_\_
3. Do you react abnormally to any medication?  Yes  No Which? \_\_\_\_\_
4. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?  
 Yes  No If yes, when and where? \_\_\_\_\_
5. Have you ever been on cortisone or steroid treatment?  Yes  No When? \_\_\_\_\_
6. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?  
 Yes  No If so, how much? \_\_\_\_\_
7. Do you smoke?  Yes  No If so, how much? \_\_\_\_\_ For how long? \_\_\_\_\_
8. Are you pregnant?  Yes  No When was you last normal menstrual period? \_\_\_\_\_
9. How many pregnancies? \_\_\_\_\_ Births? \_\_\_\_\_ Breast Fed?  Yes  No How long? \_\_\_\_\_  
CHILDREN (list names and ages/birthdays): \_\_\_\_\_  
\_\_\_\_\_
10. When was your last mammogram? \_\_\_\_\_ By whom? \_\_\_\_\_
11. Do you have a family history of breast cancer? \_\_\_\_\_ Who in family? \_\_\_\_\_
12. Do you have a family history of any other cancer/disease? \_\_\_\_\_ Explain \_\_\_\_\_
13. Who is your personal physician, if any? \_\_\_\_\_ Please list all physicians presently caring for you.  
\_\_\_\_\_
14. Have you ever been under psychiatric care?  Yes  No When? \_\_\_\_\_ Why? \_\_\_\_\_
15. Have you had any recent blood work done?  Yes  No Where? \_\_\_\_\_
16. Is there anything else you think the doctor should know? \_\_\_\_\_  
\_\_\_\_\_
17. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:  
SURGICAL OPERATIONS (include where, when and why for each surgery): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
18. Serious Illness/Diseases (include when and treatment): \_\_\_\_\_  
\_\_\_\_\_

**By signing below, I agree that the above information is complete and accurate to the best of my knowledge.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_