



Waterford Plastic Surgery Center

REGISTRATION FORM



PATIENT

Name: _____ SSN: _____
 Home phone: _____ Work phone: _____ Mobile phone: _____
 Email: _____ Address: _____
 Would you like to receive once monthly emails regarding specials or new procedures? Yes _____ No _____

EMERGENCY CONTACT

Emergency contact: _____ Relationship: _____
 Home phone: _____ Office phone: _____ Mobile phone: _____

DEMOGRAPHICS

Date of birth: _____ Age: _____ Gender: _____ Marital status: _____
 Height: _____ Wt: _____ Usual blood pressure: _____

EMPLOYMENT

Employment status: _____ Occupation: _____ Company/school: _____
 Phone: _____ Address: _____

PRIMARY PHYSICIAN

Name: _____ Address: _____
 Phone: _____

REFERRAL SOURCE

Where did you hear about the practice? _____ When? _____
 Visit purpose: _____ Referring physician: _____
 Referring physician address: _____

INSURANCE INFORMATION (IF APPLICABLE)

Provider name: _____ Plan type: _____
 Plan name: _____ Name of insured: _____
 Relationship of insured: _____

ALLERGIES

| Medication | Reaction |
|------------|----------|
| | |
| | |
| | |

General allergies (i.e. mold, animals, foods, latex, etc.) _____

SOCIAL HISTORY

Alcohol drinks/wk: _____
 Tobacco use: _____ I do not smoke _____ I smoke _____ cigarettes / day
 _____ I quit _____ years ago _____ I smoke _____ cigars / day

_____ I chew tobacco
 _____ I am exposed to second hand smoke
 _____ number of pregnancies

_____ I use a nicotine patch or gum
 _____ History of iv drug abuse (_____)
 _____ number of children

CURRENT MEDICATIONS

(Includes both prescription and over the counter meds including minerals and supplements)

| Name | dose | frequency |
|------|------|-----------|
| | | |
| | | |
| | | |
| | | |
| | | |

MEDICAL HISTORY

| | SELF | FAMILY/RELATION |
|-------------------|------|-----------------|
| Nervous system | | |
| Cardiac/Heart | | |
| Hematologic/Blood | | |
| Pulmonary/Chest | | |
| Renal/Urinary | | |
| Digestive | | |
| Skin | | |
| Breast | | |
| Endocrine/Glands | | |
| Diabetes | | |
| Thyroid | | |
| Other | | |

_____ dentures _____ contacts _____ eye drops _____ glasses

History of cancer?

| | SELF | FAMILY |
|----------|-------|--------|
| Location | _____ | _____ |
| | _____ | _____ |

Breast history: date of last mammogram _____ result: _____

SURGICAL HISTORY

| Operation | date | surgeon | complication |
|-----------|------|---------|--------------|
| | | | |
| | | | |
| | | | |
| | | | |



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REGISTRATION FORM
REVIEW OF SYSTEMS



REVIEW OF SYSTEMS

Please circle any of the following if they are positives past or present and explain below.

General: weight change, sleep changes, appetite change, fatigue, fever/chills

HEENT:

Head: headache, head injury

Eyes: vision change, pain, redness, flashing lights, glaucoma, cataracts

Ears: decreased hearing, ringing, earache, discharge

Nose: stuffiness, discharge, itching, hay fever, nosebleeds, and sinus pain

Throat: problems with teeth or gums, dry mouth, sore throats, hoarseness

Neck: lumps, swollen glands, goiter, pain, stiffness

Skin: rashes, bruising, lumps, itching, dryness, color change, change in hair or nails, delayed healing

Neurological: dizziness, lightheadedness, fainting, seizures, weakness, paralysis, numbness, tingling, tremor

Endocrine: heat or cold intolerance, excessive sweating, excessive urination, change in glove or shoe size

Respiratory: cough, sputum, blood, difficulty breathing, wheezing, pain, TB exposure

Cardiovascular: chest pain, tightness, palpitations, orthopnea, edema

GI: trouble swallowing, appetite change, nausea, heartburn, bloody stool, constipation, diarrhea, pain, jaundice, tarry stools, change in bowels

GU: frequency, night urination, urgency, burning, blood in urine, infections, kidney stones, incontinence, hesitancy

Blood: claudication, leg cramps, varicose veins, blood clots, easy bruising, easy bleeding, anemia, transfusion

Musculoskeletal: muscle or joint pains, stiffness, gout, back pain, swelling

Immune: problems healing, disorders

Psych: nervousness, depression, memory loss, stress, or disturbing thoughts

Men/Women: lumps, pain, discharge, STD's, any other problems

Details of positives: