COSMETIC SURGERY SPECIALISTS
Alan B. Brackup, M.D., F.A.C.S.

PLEASE PRINT and COMPLETE ALL INFORMATION

Appointment Date: _____

Patient Name: _____ _____ _____ D.O.B. ___/___/___ Age:____ Sex:__M __F
First Middle Last

Address: _____
Street # & Name City State Zip Code

Your Telephone: Home _____ - _____ - _____ Cell: _____ - _____ - _____ Work: _____ - _____ - _____

Pharmacy Name & Phone Number: _____ ** **May we call you at work? ___Y ___N**

S.S. # _____ _____ _____ S____ M____ D____ W____ Spouse Name: _____
NECESSARY FOR IDENTIFICATION Marital Status

***May we contact you by email? ___ Y ___ N Email address: _____**

Your Occupation: _____ Your Employer: _____

Your Employer Address: _____

Emergency Contact Person: _____ Relationship: _____ Telephone: _____

Spouse/Parent Name: _____ _____ _____ S.S.# _____-_____-_____ D.O.B. ____/____/____
Spouse/Parent Address: _____
Spouse/Parent Occupation: _____ Employer Name: _____
Spouse/Parent Employer Address: _____ _____ _____ _____
Street # and Name City State Zip Code

****How did you hear about our office? _____**

****** THIS BOX MUST BE COMPLETED IN FULL ******

***Referring Physician** _____ Phone: _____ Fax:_____
First Last

Address of Referring Physician: _____
Street # & Name City State Zip

***Family Physician** _____ Phone: _____ Fax: _____
First Last

Address of Family Physician: _____
Street # & Name City State Zip

****PLEASE ANSWER THE FOLLOWING QUESTIONS**

1. **List your reason for today's visit**: _____
   _____
2. Do you have a history of eye problems, dry eyes, or eye surgery ____ YES ____ NO If yes, please explain: _____
   _____
3. Do you have cataracts? ___ YES ___ NO
4. Have you had cataract surgery? ___ YES ___ NO Which Eye(s)? _____ When? _____
5. Do you wear glasses? ____ YES ___ NO Contact Lenses? ___ YES ___ NO
6. Any history of skin cancer? ___ YES ___ NO If yes, what area? _____
7. Any history of radiation treatment to the face? ___ YES ___ NO
8. Do you take blood thinners? ___ YES ___ NO If yes, please list: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS?

Please List All <u>Medicine</u> Allergies:

_____ _____
_____ _____
_____ _____

****ARE YOU ALLERGIC TO LATEX**? ___ YES ___ NO

*** List <u>all medications</u> you are presently taking including <u>strength and how often:</u>**

_____ __mg __x a Day _____ __mg __x a Day _____ __mg __x a Day

_____ __mg __x a Day _____ __mg __x a Day _____ __mg __x a Day

_____ __mg __x a Day _____ __mg __x a Day _____ __mg __x a Day

_____ __mg __x a Day _____ __mg __x a Day _____ __mg __x a Day

_____ __mg __x a Day _____ __mg __x a Day _____ __mg __x a Day

Please list **ALL** vitamins, supplements, and/or herbs you are presently taking. _____
_____

Do you presently smoke? ___ YES ___ NO If yes, amount per day _____ How long? _____
Have you ever smoked? ___ YES ___ NO If yes, amount per day _____ How long? _____

Has any family member had: [ ] diabetes [ ] heart attack or severe heart disease [ ] problem with anesthesia

List below all your hospitalizations for illness, surgery, accident or fracture:
Year: _____ Hospital: _____ Reason: _____
Year: _____ Hospital: _____ Reason: _____
Year: _____ Hospital: _____ Reason: _____
Year: _____ Hospital: _____ Reason: _____
Year: _____ Hospital: _____ Reason: _____

Have you ever had Tuberculosis (TB)? ____ YES ____ NO
Have you ever been exposed to Tuberculosis (TB) within the past year? ____YES ____ NO

Have you ever had or been treated for any of the following: (Please check all that apply)

__allergy/hay fever
__anemia
__back problems/pain
__cancer
__diabetes
__epilepsy/seizure disorder
__eye injury/disease
__fainting spells
__frequent colds
__head injury
__heart trouble
__high blood pressure
__nervousness
__lung trouble
__peptic/stomach ulcers
__arthritis
__sinus trouble
__skin rash/disease
__bleeding disorder
__asthma/wheezing
__bone or joint deformity
__broken bones or bone disease
__shortness of breath
__cancer, cyst, growth or tumor
__chronic cough/recent cold
__chest pain or pressure
__coughing or vomiting blood
__change in bowel habits or bleeding
__chills, fever, night sweats
__dizziness or passing out spells
__double vision or blindness
__difficult in sleeping
__ringing in ears
__excess tiredness/fatigue
__weakness in a limb
__numbness in a limb
__emphysema
__prolonged hoarseness
__pneumonia
__tightness in chest
__excessive worry or depression
__frequent or severe indigestion
__frequent or severe headaches
__kidney stone or blood in urine
__liver disease or jaundice
__loss of appetite, nausea or vomiting
__neuritis (inflammation of nerve)
__pain in shoulder, arms or hands
__tendonitis weak wrists
__repeated diarrhea
__constipation
__frequent urination
__hepatitis
__AIDS or ARC
__stroke
__infections
__burning urination
__palpitation or pounding chest
__recent gain or loss of weight
__rheumatic fever
__cataract/glaucoma
__sugar or albumin in urine
__scarlet fever
__severe ear, nose, throat trouble
__swelling of ankles or feet
__swollen or painful joints
__tuberculosis
__bladder infection
__thyroid trouble
__heart murmur
__gout
__phlebitis of vein
__trouble concentrating
__heart attack, heart valve
__congestive heart failure
__Mitral Valve Prolapse
__pace maker

PLEASE BRING YOUR INSURANCE CARD(S) AND A FORM OF PHOTO IDENTIFICATION WITH YOU AT YOUR VISIT.

A COPY OF YOUR INSURANCE CARD(S) AND YOUR PHOTO ID WILL BE MADE AT THAT TIME.

IF YOU DO NOT HAVE YOUR INSURANCE CARD(S) OR REFERRAL WITH YOU AT THE TIME OF YOUR VISIT YOUR APPOINTMENT WILL NEED TO BE RESCHEDULED.

Please complete the following information:

Primary Insurance Information
Insurance Name: _____
Claims Address: _____
_____
City;State;Zip: _____
Identification #: _____
Group #: _____
Insured's Name: _____
Insured's Date of Birth: ___ _____

Secondary Insurance Information
Insurance Name: _____
Claims Address: _____
_____
City;State;Zip: _____
Identification #: _____
Group #: _____
Insured's Name: _____
Insured's Date of Birth: _____

ALL PATIENTS PLEASE READ AND SIGN

I authorize Cosmetic Surgery Specialists to release any medical or other information

to my insurance company necessary to process claims for services rendered by them.

I authorize payment of medical benefits, including government benefits to Cosmetic Surgery Specialists.

This authorization will remain in effect until revoked by me in writing.

Furthermore, I understand that Cosmetic Surgery Specialists and Dr. Alan Brackup <u>DO NOT</u>

participate in PENNSYLVANIA MEDICAID, ACCESS or MANAGED CARE ROGRAMS.

I understand that if I am enrolled in one of these plans, I will be balance billed for services rendered.

I understand that I am financially responsible for all charges whether or not paid by said insurance company.

_____ _____/_____/_____
Patient / Authorized Person / Insured Signature Date

COSMETIC SURGERY SPECIALISTS

ACKNOWLEDGEMENT TO RELEASE INFORMATION

Our practice is committed to securing the privacy of your health information, so if you chose to have other sources receive any information regarding your treatment in our office please complete the following information and sign at the bottom of this form.

I wish to be contacted in the following manner (check all that apply):

1. Home Telephone: (___)_____
_____ Leave message with detailed information
_____ Leave message with call back number

2. Work Telephone: (____)_____
_____ Leave message with detailed information
_____ Leave message with call back number

3. Cell Telephone: (____)_____
_____ Leave message with detailed information
_____ Leave message with call back number

4. Written Communication:
_____ Mail to home address
_____ Fax to this number: (____)_____

I hereby give my permission for Cosmetic Surgery Specialists to disclose information regarding my treatment to the following: (please print)

Name	Phone #	Relationship
Name	Phone #	Relationship
Name	Phone #	Relationship

Physician Name	Address	City/State	Zip Code
Physician Name	Address	City/State	Zip Code

By signing this release, I authorize my medical records to be faxed or mailed upon my request.

Name (please print) **Date of Birth**

Signature **Date**