



MICHAEL J. STREITMANN, M.D., F.A.C.S.
 Board Certified - American Board of Plastic Surgery

NEW PATIENT INFORMATION

General Information

Responsible Party Name Last: _____
 First: _____
 Patient Name (if different) Last: _____
 First: _____
 Street Address: _____
 City: _____ State: _____ Zip: _____
 Date of Birth: _____ Responsible Party DOB: _____
 Male: Female:
 Social Security Number: _____ Marital Status: S M W D

Contact Information

Home Phone: _____
 Home Fax: _____
 Cell Phone: _____
 Cell Phone Carrier: _____
 Beeper: _____
 Work Phone: _____
 Email: _____
 Pharmacy Phone: _____
 Contact Preference: Home Cell Work Email

Emergency Contact

Name: _____
 Relationship: _____
 Home Phone: _____
 Work Phone: _____
 Cell Phone: _____
 Beeper: _____

Employer Information

Occupation: _____
 Employer: _____
 Street Address: _____
 City: _____ State: _____ Zip: _____

Physician Information

Referring Physician: _____
 Phone: _____ Fax: _____
Primary Care: _____
 Phone: _____ Fax: _____



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SURGERY / ANESTHESIA / MEDICAL HISTORY

Have you ever had surgery? No: Yes:
 Have you ever had anesthesia complications of any kind? No: Yes:
 Please describe: _____

Are you pregnant? No: Yes:
 Height: _____ Weight: _____

Have you or do you still have:

Asthma	No: <input type="checkbox"/> Yes: <input type="checkbox"/>
High Blood Pressure	No: <input type="checkbox"/> Yes: <input type="checkbox"/>
Heart Trouble	No: <input type="checkbox"/> Yes: <input type="checkbox"/>
Hepatitis or Liver Trouble	No: <input type="checkbox"/> Yes: <input type="checkbox"/>
Kidney Trouble	No: <input type="checkbox"/> Yes: <input type="checkbox"/>
Diabetes	No: <input type="checkbox"/> Yes: <input type="checkbox"/>
Epilepsy or Seizures	No: <input type="checkbox"/> Yes: <input type="checkbox"/>
Stroke	No: <input type="checkbox"/> Yes: <input type="checkbox"/>
Problem Scarring	No: <input type="checkbox"/> Yes: <input type="checkbox"/>
Have you been advised or had psychiatric care?	No: <input type="checkbox"/> Yes: <input type="checkbox"/>
Others Not Listed:	_____

Do you smoke? No: Yes: How much? _____
 Do you drink? No: Yes: How much? _____
 Do you have children? No: Yes: How many? _____

List medications, vitamins or herbal supplements: _____

List allergies to medications and/or anesthesia: _____

Financial Disclosure

I have insurance coverage and assign directly all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the use of this signature on all my insurance submissions.

I understand all of my financial responsibilities as explained above.

Signature: _____ Date: _____

Privacy Notice and Consent

We are required by law to protect the privacy of your Health Information. The attached Notice of Privacy Practices explains our practices and your rights. Please sign below to signify that you have read the Notice and that you allow us to disclose your health information to your family members (i.e., giving them lab or appointment information to a family member answering your phone or in an emergency situation). If this concerns you, please discuss with Dr. Streitmann.

Signature: _____ Date: _____

Photo Consent: I authorize Michael J. Streitmann, M.D., P.A. to take pre-operative, intra-operative, and post-operative photographs. I authorize my photographs to be used for Medical Internet Office use.

Signature: _____ Date: _____