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: ☐	Yes: ☐
High Blood Pressure	No: ☐	Yes: ☐
Heart Trouble	No: ☐	Yes: ☐
Hepatitus or Liver Trouble	No: ☐	Yes: ☐
Kidney Trouble	No: ☐	Yes: ☐
Diabetes	No: ☐	Yes: ☐
Epilepsy or Seizures	No: ☐	Yes: ☐
Stroke	No: ☐	Yes: ☐
Problem Scarring	No: ☐	Yes: ☐
Have you been advised or had psychiatric care?	No: ☐	Yes: ☐

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: _____