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

Patient Information

Last Name: _____ First: _____ Middle: _____
DOB: _____ SS#: _____ Male: ___ Female ___
Marital Status: S__ M __ W __ D __

Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____ Cell Carrier: _____
Email: _____
Pharmacy: _____/#_____ Zip: _____
Contact Preference: Home__ Cell__ Work__ Email__

Employer Information:

Employer: _____
Occupation: _____
Contact #: _____

Emergency Contact:

Name: _____
Relationship: _____
Contact #: _____

Referring Physician:

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____

Primary Care Physician:

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____

Policy Holder Information: Self ___ Other ___

Last Name: _____First:_____Middle:_____
Relationship to Patient: _____
DOB: _____ SS#_____ Male ___ Female____
Address (if different from patient):_____
City: _____ Zip: _____ Contact #:_____

Primary Insurance:

Name: _____
Policy #: _____

Secondary Insurance:

Name: _____
Policy #: _____

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Surgery / Anesthesia / Medical History

Have you ever had surgery? ☐No ☐Yes

If yes, please list: _____

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
Hepatitis 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

Appointment Scheduling, Reminders, Special Offers: I authorize Michael J. Streitmann, M.D., P.A. to communicate with me regarding the above.

Signature: Date: