



**Scott A. Spiro, M.D., F.A.C.S.**  
Diplomate of the American Board of Plastic Surgery  
Diplomate of the American Board of Surgery

**PATIENT INFORMATION**

Today's Date \_\_\_\_\_

Mr.  Miss

Mrs.  Ms. Patient's Name \_\_\_\_\_

Home Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Social Security # \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Marital Status: \_\_\_ Married \_\_\_ Single \_\_\_ Other

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_\_ Home Phone \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Cell/Other Phone \_\_\_\_\_

I consent to being contacted by e-mail regarding upcoming promotions/special events within the office.

I consent to being contacted by text messaging (SMS)

I would like to be contacted regarding social media applications such as; Twitter, Facebook, Linked In, etc

Patient's Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Business Address, City, Zip Code \_\_\_\_\_

Business Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_

Family Internist \_\_\_\_\_ Phone \_\_\_\_\_

Internist's Address \_\_\_\_\_

Patient Referred By \_\_\_\_\_

Has this office treated any member of your family? Yes \_\_\_ No \_\_\_ If yes, whom? \_\_\_\_\_

**PURPOSE OF INITIAL CONSULTATION**

**Please describe in your own words what brings you here to see Dr. Spiro:**

\_\_\_\_\_  
\_\_\_\_\_

Please check the procedure you are interested in:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Brow Lift      | <input type="checkbox"/> Brown Spots           | <input type="checkbox"/> Liposuction   | <input type="checkbox"/> Breast Reconstruction              |
| <input type="checkbox"/> Face Lift      | <input type="checkbox"/> Wrinkles              | <input type="checkbox"/> Tummy Tuck    | <input type="checkbox"/> Breast Reduction                   |
| <input type="checkbox"/> Eyelid Surgery | <input type="checkbox"/> Acne                  | <input type="checkbox"/> Gynecomastia  | <input type="checkbox"/> Breast Augmentation                |
| <input type="checkbox"/> Rhinoplasty    | <input type="checkbox"/> Ear Surgery           | <input type="checkbox"/> Vaginalplasty | <input type="checkbox"/> Breast Lift                        |
| <input type="checkbox"/> Fat Grafting   | <input type="checkbox"/> Other Body Contouring | <input type="checkbox"/> Botox         | <input type="checkbox"/> Facial Fillers(Restylane/Juvederm) |

Other, please specify \_\_\_\_\_

Have you consulted other Physicians, including Plastic Surgeons, regarding this? \_\_\_\_\_

If Yes, Physician's Name \_\_\_\_\_

**INJURIES**

If consultation is related to an injury, date of injury \_\_\_\_\_  
Injury related to:      Work                  MVA                  Other \_\_\_\_\_  
Have you been previously treated for this injury? \_\_\_\_\_  
Name of Hospital \_\_\_\_\_                  Name of Physician \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_                  Relationship \_\_\_\_\_  
Home Phone \_\_\_\_\_                  Work/Other Phone \_\_\_\_\_

**INSURANCE – PRIMARY** (Please fill out completely)

Primary Insurance Company \_\_\_\_\_  
Claims Address \_\_\_\_\_  
Telephone Number \_\_\_\_\_  
ID # \_\_\_\_\_                  Group Name/# \_\_\_\_\_  
Subscriber/Insured \_\_\_\_\_                  Subscriber Employer \_\_\_\_\_  
Subscriber Soc Sec # \_\_\_\_\_                  Subscriber Birth Date \_\_\_\_\_  
Relationship of Patient to Subscriber \_\_\_\_\_

**INSURANCE – SECONDARY** (Please fill out completely)

Secondary Insurance Company \_\_\_\_\_  
Claims Address \_\_\_\_\_  
Telephone Number \_\_\_\_\_  
ID # \_\_\_\_\_                  Group Name/# \_\_\_\_\_  
Subscriber/Insured \_\_\_\_\_                  Subscriber Employer \_\_\_\_\_  
Subscriber Soc Sec # \_\_\_\_\_                  Subscriber Birth Date \_\_\_\_\_  
Relationship of Patient to Subscriber \_\_\_\_\_

**Authorization to Release Protected Health Information to Your Health Insurance Carrier**

Your authorization is required to perform the following tasks with your health insurance carrier:

- Initiate a request for pre-determination of benefits
- Obtain pre-certification for scheduled procedures
- Submit claims for services to your carrier either electronically or on hardcopy claim form
- Follow up on the status of claims
- Appeal improperly processed claims

Your signature below authorizes the release of demographic, financial and protected health information to the insurance carriers listed above.

Patient Signature \_\_\_\_\_

If patient is under age 18, Signature of Parent/Guardian \_\_\_\_\_

**Photographic Consent**

I understand that photographs and/or videos will be taken at the time of my consultation with Dr. Scott Spiro, as well as during and after my procedure. I understand that these photographs and/or videos will be kept strictly confidential and maintained as a part of medical records. Photographs may be submitted to insurance carriers for the purpose of coverage determinations. No further use of my photographs and/or videos will be performed without my written consent.

Patient Signature \_\_\_\_\_

If patient is under age 18, Signature of Parent/Guardian \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**MEDICAL HISTORY**

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ Any Significant Weight Change in the past year? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes how much? \_\_\_\_\_ Loss / Gain

When was your most recent physical check-up? \_\_\_\_/\_\_\_\_/\_\_\_\_

**Where?**

Did it include **Blood Work?**: Yes \_\_\_\_\_ No \_\_\_\_\_

Physician Name: \_\_\_\_\_

**EKG?**: Yes \_\_\_\_\_ No \_\_\_\_\_

Address: \_\_\_\_\_

**Chest X-Ray?**: Yes \_\_\_\_\_ No \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**Do you have High Blood Pressure?** Yes \_\_\_\_\_ No \_\_\_\_\_

**Do you have a Thyroid Condition?** Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, who follows you on a regular basis?

If Yes, who follows you on a regular basis?

Physician Name: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**Have you had or do you have any disorders of the following?**

- |  |                                       |                                |  |   |
|--|---------------------------------------|--------------------------------|--|---|
| <input type="checkbox"/> High Cholesterol  | <input type="checkbox"/> Blood        | <input type="checkbox"/> Brain | <input type="checkbox"/> Breast              | <input type="checkbox"/> Urinary System |
| <input type="checkbox"/> Heart Condition   | <input type="checkbox"/> Bones/Joints | <input type="checkbox"/> Ears  | <input type="checkbox"/> Face                | <input type="checkbox"/> Nervous System |
| <input type="checkbox"/> Intestines/Bowels | <input type="checkbox"/> Arms/Legs    | <input type="checkbox"/> Liver | <input type="checkbox"/> Blood Vessels       | <input type="checkbox"/> Lungs          |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Nose/Throat  | <input type="checkbox"/> Skin  | <input type="checkbox"/> Reproductive System | <input type="checkbox"/> Anemias        |

\*\*Please Explain \_\_\_\_\_  
\_\_\_\_\_

**\*\* Do you see a physician on a regular basis for any other Medical Problems?** Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, Please describe the Medical Condition:  
\_\_\_\_\_

Who follows you on a regular basis for this condition?

Physician Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

- Do you have a tendency to suffer from motion sickness (cars, airplanes, boats, etc..) or have had nausea from anesthesia ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Have you ever reacted badly to being put to sleep for surgery? ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
If Yes, please explain: \_\_\_\_\_
- Have you ever had a reaction to local anesthetics? (novacaine)..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you bleed or bruise unusually? ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Are you a slow or poor healer? ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you form large scars or keloids? ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have skin diseases? (hives, eczema, psoriasis etc..) ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have shortness of breath when walking? ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you or have you had any back trouble? ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Does your religion prohibit blood transfusions? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

**Women Only:**

Have you ever been pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ How many times? \_\_\_\_\_

Are you pregnant now? Yes \_\_\_\_\_ No \_\_\_\_\_ How many children do you have? \_\_\_\_\_

Are you planning more children? Yes \_\_\_\_\_ No \_\_\_\_\_

When was your last mammogram? \_\_\_\_/\_\_\_\_/\_\_\_\_ Where? \_\_\_\_\_

When was you last menstrual cycle? \_\_\_\_/\_\_\_\_/\_\_\_\_

**PERTINENT PRE-OPERATIVE INFORMATION**

- \*Do you smoke? Yes\_\_\_ No\_\_\_ If Yes, How much per day? \_\_\_\_\_
- \*Have you ever smoked? Yes\_\_\_ No\_\_\_ If Yes, When was your last cigarette, cigar or pipe? \_\_\_\_\_
- \*Do you use a nicotine patch, chew nicotine gum or use a nicotine lozenger? Yes\_\_\_ No\_\_\_ If Yes, Which Kind? \_\_\_\_\_
- \*Does anyone in your household smoke? Yes\_\_\_ No\_\_\_
- \*Do you use recreational drugs? Yes\_\_\_ No\_\_\_ If yes, What kind? \_\_\_\_\_
- \*Do you consume Alcohol? Yes\_\_\_ No\_\_\_ If yes, How much per week? \_\_\_\_\_
- \*Caffeine Consumption? Coffee \_\_\_ Tea \_\_\_ Soda \_\_\_ How much per day? \_\_\_\_\_
- \*Do you or have you ever taken steroid medications, cortisone, or ACTH? Yes\_\_\_ No\_\_\_
- \*Do you take any Herbal Supplements or Consume Herbal Drinks, or take any other nutritional supplements? Yes\_\_\_ No\_\_\_
- \*\*Do you or have you had any significant emotional problems? Yes\_\_\_ No\_\_\_  
If Yes, please explain: \_\_\_\_\_
- \*\*Have you ever had Psychiatric/Psychological Care? Yes\_\_\_ No\_\_\_  
If Yes, please explain: \_\_\_\_\_
- \*\*Have you ever been described as having BDD (body dysmorphic disorder)? Yes\_\_\_ No\_\_\_

**ALLERGIES:** (Please list all including drugs, food, seasonal)

Are you allergic to Latex? Yes\_\_\_ No\_\_\_  
 Are you allergic to Adhesive Tape? Yes\_\_\_ No\_\_\_

**PRESCRIPTION MEDICATION** (Please list all **prescription** medications you take)

NAME	DOSAGE	HOW OFTEN	MEDICAL REASON	DOCTOR WHO PRESCRIBED THE MEDICATION

**NON-PRESCRIPTION MEDICATION** (Please list all vitamins, supplements and herbals that you take)

Are there any medications you have difficulty tolerating? (nausea, upset stomach, etc..)

**PREVIOUS SURGERIES / HOSPITALIZATIONS** (please list all)

Date	Surgery/Illness	Hospital/Physician (who treated you)

Did you have any significant complications or after effects from these procedures? Yes\_\_\_ No\_\_\_

If Yes, please explain: \_\_\_\_\_

