TULSA SURGICAL ARTS
PATIENT REGISTRATION FORM

The following information will help us serve you better. Please make every effort to fill out the information fully and accurately. Please be sure to complete all 4 pages of this form. Your responses are held strictly confidential. After completion, please email to missi@tulsasurgicalarts.com or bring hard copy with you to consult.

PERSONAL INFORMATION

Name: _____ Date of Birth: ____/____/____ Age:_____ Sex:_____

SS#: _____ Height: _____ Weight: _____ # of Biological Children: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Where May We Leave Voice or Text Messages?

( ) Home _____ ( ) Cell _____

( ) Work _____ ( ) Email _____

( ) Spouse _____ ( ) Other _____

Place of Employment: _____Occupation: _____

Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed

Name of Spouse: _____ Spouse's Employer:_____

Emergency Contact: _____

Relationship: _____ Phone: _____

Who is responsible for charges? _____

Pharmacy Information: _____

Please CIRCLE your surgeries of interest to discuss:

Arms Breast Enlargement Breast Lift Breast Reduction Butt Lift Cheeks Chin Ears Eyelids

Face Liposuction Nose Neck Mouth Wrinkles Tummy Tuck Orthognathic Other

_____

Please use the space below to give us any other information you feel would be helpful for your consultation:_____

_____

_____

Thank you for selecting our practice! May we ask how you heard about us?

Please indicate all that apply:

( ) Patient Referral. May we ask who? _____

May we acknowledge referral? ( ) Yes ( ) No

( ) Doctor Referral. May we ask who? _____

May we acknowledge referral? ( ) Yes ( ) No

( ) General Reputation or Recommendation

( ) Google or Other Internet Search. Which one? _____

( ) Speaking Engagement. Where? _____

( ) Magazine. Name? _____

( ) Newspaper. Name? _____

( ) Yellow Pages

( ) Other_____

MEDICAL HISTORY

The medical history is an extremely important part of your consultation. It helps to alert us to any potential problems that might interfere with your surgery. Please take the time to fill this out completely and accurately. If you need some help, the staff will be glad to assist you.

Do you have an advanced directive or living will? ( ) Yes ( ) No Would you like information? ( )Yes ( )No

List ALL prescription drugs you are taking:

_____

_____

List ALL non-prescription drugs you take such as aspirin, herbal medicines, etc.:

_____

List ANY diet pills you take-VERY IMPORTANT! Can cause serious problems with anesthesia:

_____

List ANY drugs to which you are ALLERGIC:

_____

List ANY contact allergies including latex or other products:

_____

Please tell us about ANY serious illnesses you have had in the past: For example, heart disease, blood pressure problems, pulmonary disease, kidney disease, diabetes, thyroid trouble, stomach ulcers, etc.:

_____

_____

Please list any operations you have had (including cosmetic surgery): Give approximate dates:

_____

_____

If applicable, please circle: Tubal ligation Hysterectomy Post-Menopausal

Describe ANY difficulties you have had with anesthesia _____

Describe ANY MAJOR injuries you have sustained (include dates) _____

Are there any hereditary disorders in your family that might be of significance? _____

_____

Do you smoke? _____ If so, what form and how much? _____

Do you drink alcohol? Please check one: ( ) None ( ) Occasional ( ) Moderate ( ) Heavy_____

Do you have or have you ever had an addiction to controlled narcotics or street drugs? _____

How is your general health? ( ) Poor ( ) Fair ( ) Good ( ) Excellent

Are you under a doctor's care? _____ If yes, who and what for?

_____

Please review the list below and check anything applicable. If you check any of the boxes below, please use the space at the bottom for any explanation that you think would be helpful. Please be as complete as possible.

( ) Severe dryness of the eyes
( ) Recurrent severe dizziness
( ) Chronic sinus problems or nasal blockage
( ) Paralysis of the face
( ) Chronic hoarseness
( ) Chest pain
( ) Chronic abdominal problems
( ) Blood in bowel movements
( ) Bleeding disorders, (you or anyone in your family)
( ) Menstrual disorder
( ) Glaucoma or blurry vision
( ) Severe headaches
( ) Recurrent fever blisters
( ) Asthma or emphysema
( ) Shortness of breath
( ) Heart disease or high blood pressure
( ) Kidney or bladder problems
( ) Blood in urine or trouble urinating
( ) Easy bruising
( ) Abnormal lump or node

( ) Problems with bones or joints

( ) Cancer

( ) Chronic skin condition

( ) Bad surgical result or unsatisfactory medical care

( ) Unexplained weight loss

( ) Emotional or Psychological problems

( ) Complications after surgery

Please explain any health issues that were checked above:

_____

_____

_____

I HAVE READ THIS FORM ENTIRELY AND HAVE COMPLETED IT FULLY AND ACCURATELY TO THE BEST OF MY KNOWLEDGE.

Patient Signature_____

Date this form was completed: _____