JOSEPH C. BANIS JR M.D. P.C.

(502) 589-8000

Patient Information as of ______________ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name ______________________________
First Middle Last

Address ______________________________
Street & Apt # City State Zip

Home Phone ____________ Cell Phone ____________ Do you have Text Messaging? ☐ No ☐ Yes

Any restrictions for contacting you? ☐ No ☐ Yes E-mail ____________

Preferred Method of Contact: ____________ (Appointment confirmations are also sent via Text Messaging.)

Age ______ Birthdate ____________ SS# ____________ Gender ☐ Female ☐ Male

Marital Status ☐ Single ☐ Married to: ____________ ☐ Other: ____________

Patient's Employer ____________ Occupation ____________

Work Phone ____________ Ext: ______ Is it okay to call you at work? ☐ Yes ☐ No

Address ______________________________
Street & Suite # City State Zip

How did you hear about Dr. Banis? (Mark all that apply)

☐ TV News ☐ TV Ad ☐ Phone Book ☐ Magazine ☐ Newsletter ☐ Seminar ☐ Salon ☐ Web

☐ Friend/Relative: ____________ ☐ Doctor: ____________ ☐ Other: ____________

If you were referred by a specific person, may we thank them? ☐ Yes ☐ No

Physician Contact

Primary Care Doctor

First & Last Name: ____________

Telephone: ____________

Referring Doctor

First & Last Name: ____________

Telephone: ____________

Emergency Contact
(Not in your household) ____________ Relationship to Patient ____________

Home Phone ____________ Work Phone ____________ Other Phone ____________

Pharmacy

Name ____________ Phone # ____________

Do you have a living will? ☐ Yes ☐ No If you need information please ask a staff member.

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Banis to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Banis and myself.

Signature ______________________________ **Date** ____________

JOSEPH C. BANIS JR M.D. P.C. (502) 589-8000

901 Dupont Road, Suite 202 , Louisville, KY 402074644

Health Information as of ______________ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient:			
DOB	Age	Height ft in	Weight lbs
Why are you seeing the doctor?			
Referring Physician:			
Primary Care Physician:			

Past Medical History

Please list all medical conditions and surgeries, including procedures done for cosmetic reasons:

MEDICAL CONDITIONS:

1. ______________
2. ______________
3. ______________
4. ______________
5. ______________

SURGICAL OPERATIONS (include where, when and why for each surgery):

1. ______________
2. ______________
3. ______________
4. ______________
5. ______________

Allergies

Do you have an allergic reaction to any medication? ☐ Yes ☐ No Which? ______________

Do you react abnormally to any medication? ☐ Yes ☐ No Which? ______________

Do you have a latex allergy? ☐ Yes ☐ No

Medications

Please list all present medications, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. Include over-the-counter medications.

____

____

____

Family History

List diseases relatives have had, including cancer heart disease, stroke, clotting problems or problems with anesthesia

____

____

Social History

Occupation ______________ Employer ______________

Marital Status ______________ Spouse Name ______________

How many pregnancies? ________ Children (names and ages) ______________

Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?

☐ Yes ☐ No If so, how much per week? ______________

Do you use **tobacco**? ☐ Yes ☐ No If so, how much? ________ For how long? ________

Review of Systems

DO YOU CURRENTLY HAVE........... (You must circle an answer for each individual item)

Constitutional Symptoms		
Weakness	Yes	No
Weight Loss	Yes	No
Fever/Chills	Yes	No
Eyes		
Glaucoma	Yes	No
Glasses or Contact Lenses	Yes	No
Dry Eyes, Excess Tearing	Yes	No
Ears, Nose, Mouth, Throat		
Decreased Hearing	Yes	No
Airway Obstruction (Nasal)	Yes	No
Dentures, bridges, capped teeth or crowns	Yes	No
Loose teeth	Yes	No
Cosmetic bonding to teeth	Yes	No
Neck Lumps	Yes	No
Cardiovascular		
Heart Attack	Yes	No
Chest Pain/Angina	Yes	No
Palpitation or Irregular Heartbeat	Yes	No
Heart murmur	Yes	No
High Blood Pressure	Yes	No
Low Blood Pressure	Yes	No
Abnormal EKG	Yes	No
Rheumatic Fever	Yes	No
On Heart Medication	Yes	No
Heart Failure	Yes	No
Swelling in Ankles	Yes	No
Chest Pain with Exercise	Yes	No
Respiratory		
Asthma/Wheezing	Yes	No
Bronchitis	Yes	No
Pneumonia (or history of)	Yes	No
Tuberculosis	Yes	No
Smokers Cough	Yes	No
Emphysema	Yes	No
Shortness of Breath	Yes	No
Chronic Breathing Difficulty	Yes	No
Other Lung Problems	Yes	No
Gastrointestinal		
Hepatitis (or history of); Yellow Jaundice	Yes	No
Gallstones or Gallbladder Trouble	Yes	No
Cirrhosis of the Liver	Yes	No
Ulcers	Yes	No
Gastritis/ Colitis	Yes	No
Problem Constipation	Yes	No
Chronic Abdominal Pain	Yes	No
(Hiatal/Abdominal/Groin) Hernia	Yes	No
Heartburn/Indigestion	Yes	No
Genitourinary		
Kidney Disorder	Yes	No
Blood in Urine	Yes	No
Kidney/Bladder Infection (or history of)	Yes	No
Kidney Stones (or history of)	Yes	No
Difficulty Urinating/Urinary Retention	Yes	No

Musculoskeletal		
Arthritis/Pain in Joints	Yes	No
Fracture of Neck or Spine (or history of)	Yes	No
Skin		
Skin Disorders, Dermatitis	Yes	No
Heavy Sun Exposure/Use of Tanning Beds	Yes	No
Blistering Sunburn in Past	Yes	No
Rash	Yes	No
Skin Cancer (or history of)	Yes	No
Changes in Moles (growth, color)	Yes	No
Pressure Ulcers/ Diabetic Ulcers	Yes	No
Breast		
Breast Lump	Yes	No
Breast Pain	Yes	No
Breast Cysts, Tumors, Abscesses	Yes	No
Nipple Discharge (Apart from Normal Lactation)	Yes	No
Male Breast Enlargement	Yes	No
History of Breast Cancer or Mastectomy	Yes	No
Date of Last Mammagram:		
Neurological		
Tingling, Numbness, or Weakness of Extremities	Yes	No
Seizures, convulsions, fainting spells or black outs	Yes	No
Stroke	Yes	No
Palsy or Paralysis (and what level)	Yes	No
Psychiatric		
Nervous Breakdown	Yes	No
Anxiety Disorder	Yes	No
Insomnia	Yes	No
Alcohol Adiction or Drug Dependency	Yes	No
Self-Destructive Tendencies	Yes	No
Bipolar Disorder or Depression	Yes	No
Psychiatric Hospitalization or Care	Yes	No
Endocrine		
Thyroid Problems/Goiter	Yes	No
Diabetes	Yes	No
Insulin Dependency?	Yes	No
Diabetic foot ulcers, infections?	Yes	No
Cortisone or Steroid Treatment (or history of)	Yes	No
Hematologic/Lymphatic		
Bleeding Tendency or Disorder	Yes	No
Abnormal Bleeding after Tooth Extraction	Yes	No
Blood Transfusion	Yes	No
Anemia	Yes	No
Easy Bruising	Yes	No
Lymphedema	Yes	No
Allergic/Immunologic		
Hay Fever	Yes	No
Major Allergies	Yes	No
Lupus, Scleroderma, Rheumatoid Arthritis	Yes	No
Infectious		
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No
Gynecologic		
Missed or irregular last menstrual period	Yes	No

Health Questions

1. When was your last physical exam? ____________ By whom? ____________________
2. When was your last eye examination? ____________ By whom? ____________________
3. When and where was your last chest x-ray? ____________ EKG? ____________________
4. Please list all physicians presently caring for you. ____________________
   ____
5. Have you had any recent blood work done? ❒ Yes ❒ No Where? ____________________
6. Is there anything else you think the doctor should know? ____________________
   ____

By signing below, I agreee that the above information is complete and accurate to the best of my knowledge.

Signature: ______________________________ Date: ____________

Reviewed By: ____

Joseph C. Banis MD
Aesthetic and Reconstructive Surgery

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read the Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the form. I also understand my rights to access and control such protected health information.

Patient Name: ____________________ **DOB:** ____________________

Patient Signature: ____________________ **Date:** ____________________

FOR OFFICE USE ONLY:

If patient did not return receipt, document "good faith effort" to provide patient with this notice and reason receipt was not obtained.

Signature of MD or
Privacy Officer: ______________________________ **Date:** ______________

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to an individual's office instead of to their home.

I wish to be contacted in the following manner (check all that apply):

☐ Home telephone____________________
- ☐ OK to leave message with detailed information
- ☐Leave message with call-back number only.

☐ Work telephone ____________________
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ OK to mail to my home address
- ☐ OK to fax to my work/office
- ☐ Please mail all correspondence to:

____

____

____

☐ Other ______________________________

You may disclose my information to the following people (family and friends only – you do not need to list other Healthcare Providers on this form):

______________________________ Name ____________________ Phone #

______________________________ Name ____________________ Phone #

______________________________ Name ____________________ Phone #

______________________________ Patient Signature ____________________ Date

______________________________ Print Name ____________________ Date