PLASTIC SURGICAL ASSOCIATES, INC.

2000 Washington St., Suite 444
Newton, MA 02462
617-244-0990 Fax: 617-969-4044

Matthias B. Donelan, M.D.
Daniel N. Driscoll, M.D.

DATE ______________

PATIENT INFORMATION (PLEASE COMPLETE ALL ITEMS AND PRINT)

Patient's Name ______________ Age _____ Date of Birth ______________

Home Address ______________ City ______________ State ________ Zip ________

Home Phone ______________ Cell ______________ Married ☐ Single ☐ Widow (er) ☐ Divorced ☐

Patient's Occupation ______________ Patient's Employer ______________

E-mail ______________ SS# ______________

Emergency Contact ______________ Phone ______________

Family Internist / Pediatrician ______________ Address ______________

Referred by ______________ Address ______________

Has this office previously treated any member of your family? Yes ☐ No ☐ If Yes, whom ______________

FINANCIAL RESPONSIBILITY

Bill will be paid by: Patient ☐ Spouse ☐ Father ☐ Mother ☐ Workmen's Comp. ☐ Other ☐ ______________ (specify)

Name of Spouse/Parent ______________ Spouse/Parent's Occupation ______________

Spouse/Parent's Employer ______________ Address ______________

Business Phone ______________ Ext. ______________

HEALTH INSURANCE

All referrals are the responsibility of the patient.

Blue Shield: Yes ☐ No ☐ Certificate No. ________ Subscriber's Name ______________

Medicare: Yes ☐ No ☐ Claim No. ______________

Medex: Yes ☐ No ☐ Billing Control No. ______________

Other Health Insurance (Specify) ______________

IF AN ATTORNEY IS INVOLVED

Attorney's Name ______________

Address ______________ Phone ______________

REV 7/10

DESCRIBE WHAT BRINGS YOU HERE: ____________________

DO NOT WRITE BELOW

IF INJURY, Date ____________ Motor Vehicle ☐

Pedestrian ☐ Animal Bite ☐ At Work ☐ Other ☐ ____________ (specify)

PAST MEDICAL HISTORY

Height ____________ Present Weight ____________

Intentional weight loss? Yes ☐ No ☐ How much? ________ lbs.

PREVIOUS SURGERY (Please List)

Operation	Year	Complications, if any

SERIOUS INJURIES (Please List)

Type	Year	After Effects

MEDICATIONS, DRUGS

Please list **ALL** medications you are now taking (including birth control pills, diuretics (water pills), blood pressure or heart medications, tranquilizers, hormones, steroid medications, cortisone, blood thinners, aspirin, bufferin, vitamins, etc.) ____________

MATERNAL HISTORY

Have you ever been pregnant? YES ☐ NO ☐ If Yes, how many times? ____ How many children do you have? ____________

Are you now pregnant? ____________________ Are you planning more children? YES ☐ NO ☐ Don't know ☐

GENERAL

Are you allergic to any pills, drugs, or medicines? Yes ☐ No ☐ If yes, name________________________

Have you ever had a bad reaction to any anesthetic? . . . . Yes ☐ No ☐ ____________

Do you have high blood pressure? . . . . Yes ☐ No ☐ ____________

Do you smoke cigarettes? . . . . Yes ☐ No ☐ ____________

Do you bleed unusually easily (from cuts, surgery)? . . . . Yes ☐ No ☐ ____________

Do you form bad scars or keloids? . . . . Yes ☐ No ☐ ____________

Have you ever had psychiatric care? . . . . Yes ☐ No ☐ ____________

Have you ever seen other plastic surgeons about the SAME problem that brings you here? . . . . Yes ☐ No ☐ ____________

LOCAL PROBLEMS

Have you had any serious illnesses of the following? (Circle if YES)

Brain	Nose	Heart	Bones	Blood	Extremities	Eyes	Breasts
Abdomen	Reproduction	Endocrine (Diabetes)	Ears	Lungs	Urinary	Nervous	Other

If circled, please explain: ____

____

____

____

PRIVACY NOTICE RECEIVED

X ____

Signature of Patient or Authorized Representative | Name (Please Print) | Date

AUTHORIZATION AND CONSENT

I request that payment under the medical insurance progam be made directly to the above named provider on any unpaid bills for services provided on or after the date indicated below. I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or carriers of insurance companies, any information needed for this or a related Medicare or insurance claim. I understand that I am financially responsible for all charges not covered by my insurance, including those resulting from my failure to obtain the necessary referral and/or other authorizations from my primary care and/or referring physician when required. I permit a copy of this authorization to be used in place of the original.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE **X** ____________________ DATE ____/____/____

RELATIONSHIP TO PATIENT____________________

– DO NOT WRITE ON THIS PAGE –

PHYSICAL EXAMINATION

ADVICE

SPECIAL NOTES (Routine ☐)

☐ Autotransfusion ________________ Units

Alternative methods of treatment, risks, expectations, limitations discussed: Yes ☐ No ☐ Fees discussed: Yes ☐ No ☐__________

Schedule op: Yes ☐ (When)____________ Will call ☐ No ☐ Photos required: Yes ☐ No ☐ Photos taken: Yes ☐ No ☐

Where ___________ Inp. ____________ Out Pt. ____________ Min. ____________ Anes ____________ Time _______