

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 Other Phone

Any restrictions for contacting you? No Yes E-mail

Can we contact you for:
Promotional Info No Yes
Procedure Info No Yes

Contact Restrictions:

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 our office?

(Mark all that apply)

- Tucson Lifestyle US West DEX Dexknows.com jnelsonmd.com plastic surgery.com iEnhance.com
Phone Book(Other) Magazine Newsletter Walk-in Seminar Salon Other Website
Attorney Insurance
Friend/Relative: Doctor: Other:

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

Emergency Contact
(Not in your household)

Relationship to Patient

Home Phone Work Phone Other Phone

Areas of Interest: (mark all that apply)

Facial Procedures

- Blepharoplasty (Eyelid Lift)
Botox/Dysport
Brow or Forehead Lift
Rhinoplasty (Nose Reshaping)
Facial Liposuction (Neck, Jowls)
Face or Neck Lift
Lip Enhancement/ Wrinkle Fillers (Injections)
Otoplasty (Ear Pinning)/ Earlobe Repair

Breast Procedures

- Breast Augmentation/Lift/Reduction
Breast Reconstruction
Nipple Reduction or Inversion

Body Procedures

- Abdominoplasty (Tummy Tuck)
Brachioplasty (Arm Lift)/ Thigh or Buttock Lift
Full Body Lift
Liposuction (Thighs, Abdomen, Etc.)

Other Procedures

- Chemical Peel/ Microdermabrasion
Skin Tightening/Resurfacing (Laser, Peel, Etc.)
Hyperpigmentation/ Photo Rejuvenation
Laser Hair Removal
Skin Care Products
Leg Veins
Lesions / Moles
Fat injection

I understand that office visit charges are payable on the day service is rendered.

I consent to photographs and digital images being taken to evaluate treatment effectiveness. I may be identifiable in these images. I understand they will only be used for my ongoing care unless specific written consent is given.

Signature Date

Would you like a complimentary skin evaluation while you are here today? Yes No

7416 North La Cholla Blvd , Tucson, AZ 85741

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

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

Height	ft	in	Weight	lbs
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What surgery are you considering?

DO YOU NOW OR HAVE YOU EVER HAD..... (You must circle an answer for each individual item)

Abnormal EKG	Yes	No
Abdominal Pain	Yes	No
Airway Obstruction (Nasal)	Yes	No
Any family members with anesthesia problems	Yes	No
Any family members with bleeding problems	Yes	No
Asthma	Yes	No
Back Pain	Yes	No
Blood clotting problems	Yes	No
Blood disorders	Yes	No
Blood pressure Abnormalities	Yes	No
Breast Cysts, Tumors, Abscesses	Yes	No
Bronchitis	Yes	No
Chest Pain	Yes	No
Constipation	Yes	No
Coughing	Yes	No
Dentures, bridges, capped teeth or crowns	Yes	No
Diabetes	Yes	No
Drug Habit	Yes	No
Extra Heart Beats	Yes	No
Family history of heart trouble or stroke	Yes	No
Family history of cancer	Yes	No
Fracture of Neck or Spine	Yes	No
Fractures	Yes	No
Frequent Indigestion	Yes	No
Glaucoma or Eye Problems	Yes	No
Hay Fever	Yes	No
Headaches	Yes	No
Heart Attack	Yes	No
Herpes/Cold sores/Shingles	Yes	No
History of Anorexia	Yes	No
History of Cancer- type _____	Yes	No
History of steriods	Yes	No
Hormonal Imbalances	Yes	No

Hypertension	Yes	No
Kidney or Renal Disease	Yes	No
Loose teeth	Yes	No
Lupus	Yes	No
Major Allergies	Yes	No
Missed or irregular last menstrual period	Yes	No
Nausea/Vomiting/Indigestion	Yes	No
Neck Pain	Yes	No
Neuropathy	Yes	No
Pacemaker	Yes	No
Palpitation or Irregular Pulse	Yes	No
Palsy or Paralysis	Yes	No
Piercing other than the ears	Yes	No
Pituitary Disease	Yes	No
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No
Psoriasis/Impetigo	Yes	No
Psychiatric Hospitalization or Care	Yes	No
Rash/Boil	Yes	No
Rosacea/Acne/Folliculitis	Yes	No
I read this form	Yes	No
Scarring Problems	Yes	No
Seizures	Yes	No
Self-Destructive Tendencies	Yes	No
Shortness of Breath	Yes	No
Significant Weight Changes	Yes	No
Sinus Problems	Yes	No
Skin Disorders	Yes	No
Smoker (PPD____)	Yes	No
Smokers Cough	Yes	No
Stroke	Yes	No
Swollen Glands	Yes	No
Thyroid Problems	Yes	No

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

2. Do you have an allergic reaction to any medication? Yes No Which? _____
3. Do you react abnormally to any medication? Yes No Which? _____
4. Do you have an allergic reaction to any foods? Yes No Which? _____
5. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?
 Yes No If yes, when and where? _____
6. Have you ever been on cortisone or steroid treatment? Yes No When? _____
7. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?
 Yes No If so, how much? _____
8. Do you smoke? Yes No If so, how much? _____ For how long? _____
9. Are you pregnant? Yes No When was you last normal menstrual period? _____
10. How many pregnancies? _____ Births? _____ Breast Fed? Yes No How long? _____
11. When was your last physical exam? _____ By whom? _____
12. When was your last eye examination? _____ By whom? _____
13. When and where was your last chest x-ray? _____ EKG? _____
14. Who is your personal physician, if any? _____ Please list all physicians presently caring for you.

15. Have you ever been under psychiatric care? Yes No When? _____ Why? _____
16. Have you had any recent blood work done? Yes No Where? _____
17. Is there anything else you think the doctor should know? _____

18. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:
SURGICAL OPERATIONS (include where, when and why for each surgery): _____

HOSPITALIZATIONS (include where, when and why for each admission): _____

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

Signature: _____ Date: _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Jeffrey M. Nelson, M.D. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Jeffrey M. Nelson, M.D.. I understand that diagnosis or treatment of me by Dr. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Jeffrey M. Nelson, M.D. is not required to agree to the restrictions that I may request. However, if Jeffrey M. Nelson, M.D. agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Jeffrey M. Nelson, M.D.'s Notice of Privacy Practices prior to signing this document. The Jeffrey M. Nelson, M.D.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Jeffrey M. Nelson, M.D.. This Notice of Privacy Practices also describes my rights and the Jeffrey M. Nelson, M.D.'s duties with respect to my protected health information.

Jeffrey M. Nelson, M.D. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Jeffrey M. Nelson, M.D.'s website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

