JEFFREY M. NELSON, M.D.

(520) 575-8400

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

For Office Use Only DL Copy ❒ Photo On File ❒

JEFFREY M. NELSON, M.D. **(520) 575-8400**

7416 North La Cholla Blvd , Tucson, Az 85741-2306

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

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

Height ft in	Weight lbs
What surgery are you considering?	

1. Do you have an allergic reaction to any medication? ❒ Yes ❒ No Which? _____

2. Do you react abnormally to any medication? ❒ Yes ❒ No Which? _____

3. Do you have an allergic reaction to any foods? ❒ Yes ❒ No Which? _____

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

Abnormal EKG	Yes	No	Hypertension	Yes	No
Abdominal Pain	Yes	No	Kidney or Renal Disease	Yes	No
Airway Obstruction (Nasal)	Yes	No	Loose teeth	Yes	No
Any family members with anesthesia problems	Yes	No	Lupus	Yes	No
Any family members with bleeding problems	Yes	No	Major Allergies	Yes	No
Asthma	Yes	No	Missed or irregular last menstrual period	Yes	No
Back Pain	Yes	No	Nausea/Vomiting/Indigestion	Yes	No
Blood clotting problems	Yes	No	Neck Pain	Yes	No
Blood disorders	Yes	No	Neuropathy	Yes	No
Blood pressure Abnormalities	Yes	No	Pacemaker	Yes	No
Breast Cysts, Tumors, Abscesses	Yes	No	Palpitation or Irregular Pulse	Yes	No
Bronchitis	Yes	No	Palsy or Paralysis	Yes	No
Chest Pain	Yes	No	Piercing other than the ears	Yes	No
Constipation	Yes	No	Pituitary Disease	Yes	No
Coughing	Yes	No	Positive blood test for: HIV, AIDS, Hepatitis	Yes	No
Dentures, bridges, capped teeth or crowns	Yes	No	Psoriasis/Impetigo	Yes	No
Diabetes	Yes	No	Psychiatric Hospitalization or Care	Yes	No
Drug Habit	Yes	No	Rash/Boil	Yes	No
Extra Heart Beats	Yes	No	Rosacea/Acne/Folliculitis	Yes	No
Family history of heart trouble or stroke	Yes	No	I read this form	Yes	No
Family history of cancer	Yes	No	Scarring Problems	Yes	No
Fracture of Neck or Spine	Yes	No	Seizures	Yes	No
Fractures	Yes	No	Self-Destructive Tendencies	Yes	No
Frequent Indigestion	Yes	No	Shortness of Breath	Yes	No
Glaucoma or Eye Problems	Yes	No	Significant Weight Changes	Yes	No
Hay Fever	Yes	No	Sinus Problems	Yes	No
Headaches	Yes	No	Skin Disorders	Yes	No
Heart Attack	Yes	No	Smoker (PPD____)	Yes	No
Herpes/Cold sores/Shingles	Yes	No	Smokers Cough	Yes	No
History of Anorexia	Yes	No	Stroke	Yes	No
History of Cancer- type_____	Yes	No	Swollen Glands	Yes	No
History of steriods	Yes	No	Thyroid Problems	Yes	No
Hormonal Imbalances	Yes	No			

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

_____

_____

_____

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 agreee 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

Jeffrey M. Nelson, M.D.

(520) 575-8400

Insurance Information & Authorization

(Please Print Legibly & Sign)

Patient's Name _____
First Middle Last

Primary Insurance Company _____

Policyholder's Information:

Name _____ Birthdate ___/___/___

Employer _____ Relationship to Patient _____

Does this insurance require a referral? ❒ Yes ❒ No Copay Amount $ _____

Secondary Insurance Company _____

Policyholder's Information:

Name _____ Birthdate ___/___/___

Employer _____ Relationship to Patient _____

Does this insurance require a referral? ❒ Yes ❒ No Copay Amount $ _____

Is this visit due to any type of accident? ❒ No ❒ Yes: Date of Accident _____

Type of Accident ❒ Auto: State? _____ ❒ Work Related ❒ Other: _____

All Insurance Patients – Signature on File

I request that payment of authorized benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services.

Beneficiary Signature _____ Date _____

Medicare Patients Only – Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

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