Patient Demographics

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Title	Last Name	First Name	MI
☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.			

Gender	Date of Birth (mm/dd/yyyy)	Social Security Number
☐ Male ☐ Female		

Address Line 1	
Address Line 2	
City, State, Zip	

		May we leave a message at this number? Yes	No
Home Phone		☐	☐
Cell Phone		☐	☐
Work Phone		☐	☐
Preferred Pharmacy			

		May we send billing info to this address? Yes	No
E-Mail Address		☐	☐

Marital Status	Name of Spouse/Significant Other
☐ Single ☐ Married ☐ Life Partner ☐ Widowed	

Emergency Contact & Relationship to Patient	Phone Number

Race /Ethnicity (Census Bureau purposes)	

Health Insurance Carrier	Member ID#	Policy Holder & Date of Birth

How did you find us?	Check all that apply	List Name (if applicable)
Friend	☐	
Physician	☐	
Internet	☐	
Insurance Plan	☐	
Other	☐	

Patient Name: _____

DOB: _____

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Primary Care Physician _____

Referring Physician_____

Reason for Consultation _____

Have you recently experienced any of the below symptoms on a consistent basis?

☐ Hearing Loss	☐ Allergy Symptoms	☐ Blackouts/Fainting	☐ Fever
☐ Neck Masses/Swelling	☐ Tremors /Numb Extremities	☐ Urinary Problems	☐ Chills
☐ Muscle Weakness	☐ New Skin Lesions	☐ Hot/Cold Flashes	☐ Nausea
☐ Swollen Extremities	☐ Allergic Reactions	☐ Decreased Vision	☐ HA
☐ Blurry Vision	☐ New Bleeding Problems	☐ Shortness of breath	☐ Diarrhea
☐ Breathing Difficulty	☐ Recent Mood Changes	☐ Weight Loss	☐ Dizziness
☐ Weight Gain	☐ Vomiting	☐ Sore Throat	☐ Chest Pain
☐ Night Sweats	☐ Oral Lesions	☐ Constipation	☐ Toothache
☐ Blood Clots	☐ Facial paralysis	☐ Hearing Loss	☐ Hair Loss

Do you have any history of medical disorders? (Check all that apply)

☐ Diabetes	☐ Hypertension	☐ Asthma	☐ Heart Disease	☐ COPD
☐ Breast Masses	☐ Breast Cancer	☐ Skin Cancer	☐ Kidney Disease	☐ Dry eyes
☐ Liver Disease	☐ Sleep Apnea	☐ Blood /Bleeding Disorders		

Other _____

Have you ever received radiation therapy? ☐ YES ☐ NO

If yes, when did you complete therapy? _____

Please list all past surgeries/procedures

Procedure	Date	Surgeon/ Provider

Patient Name: _____

DOB: _____

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Please list all non-surgical cosmetic treatments (Laser, Botox®, etc.)

Treatment	Date	Treatment	Date

Smoking History

Never	☐			
Smoke Currently	☐	**How Much? (PPD)**	**How Long? (years)**	
Quit	☐	**Quit Date:**	**How Much? (PPD)**	**How Long? (years)**

Do you exercise regularly? _____How much? _____
On average, how much alcohol do you consume per week? **_____**
Current Occupation: _____
How many children do you have? _____ Birth year(s): _____

Do you have any family history of (check all that apply):

☐ Breast Cancer ☐ Skin Cancer ☐ Bleeding Disorders
☐ Diabetes ☐ Hypertension ☐ Problems with Anesthesia

Please list any drugs/substances to which you are allergic

Drug	Reaction	Substance	Reaction

Please list all prescription medications you currently take

Medication	Dose	Frequency	Reason

Please list non-prescription medication, vitamins, herbal supplements you currently take

Medication	Date	Frequency	Reason

I certify that the above health information is accurate to the best of my knowledge.

X_____ Date_____

Patient Name:_____

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Consent for Treatment

PATIENT'S CONSENT FOR TREATMENT: I hereby voluntarily request and authorize Crawford Plastic Surgery to examine and treat me. I furthermore consent to peer review of my medical information when deemed necessary by Crawford Plastic Surgery. When applicable, I hereby authorize Crawford Plastic Surgery to release any information acquired during my examination or treatment to my insurance carrier for the purpose of medical claims payment. I authorize payment of medical benefits to Crawford Plastic surgery. If denied, non-covered, or remain unpaid by my insurance carrier, I will be responsible for the balance due.

I understand and agree that any credit granted shall be paid promptly in accordance with terms and agreements, that the credit grantor may add one and one half percent (1 ½ %) per month to any balance owed and in the event of default to pay reasonable collection charges and/or court costs and attorney fees.

Patient Signature_____ **Date**_____

Consent to Use and Disclose Protected Health Information

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION: Your protected health information will be used by Crawford Plastic surgery or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

THE NOTICE OF PRIVACY PRACTICES: Crawford Plastic Surgery is required to provide to you, upon request, a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in our "Notice of Privacy Practices" packet, and can be provided to you upon request.

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION: You may request a restriction on the use or disclosure of your protected health information. However, Crawford Plastic Surgery may or may not agree to your request to restrict the use or disclosure. Please consult with a practice representative if you would like additional information or clarification.

YOU MAY REVOKE THIS CONSENT AT ANY TIME: You may revoke this consent at any time; however, Crawford Plastic Surgery requires that you revoke this consent in writing. If you revoke this consent, the revocation will not affect use and disclosure of your information before the date of the request.

CHANGES TO PRIVACY PRACTICES: Crawford Plastic Surgery reserves the right to change or modify the privacy policies outlined in the Notice of Privacy Practices packet. You will be notified of changes via mail or verbally.

SIGNATURE: I have reviewed this consent form, received the packet entitled "Notice of Privacy Practices" and give my permission to Crawford Plastic Surgery to use and disclose my health information in accordance with this consent the notice provided.

Patient Signature_____ **Date**_____

Patient Name:_____

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Authorization for and Release of Medical Photographs/Slides and/or Videotapes

INSTRUCTIONS

This is a consent document that has been prepared to help inform you concerning permission to take photographs, slides, and/or videotapes and to use these images for a purpose as defined within this consent document. It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

INTRODUCTION

Medical photographs/slides and videotapes may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images. Additionally, patients may consent to release these medical photography/slides, and videotapes for a stated purpose.

1. CONSENT TO TAKE PHOTOGRAPHYS/SLIDES/VIDEOTAPES

I hereby authorize (Marcus H. Crawford, M.D. & Aisha J. McKnight-Baron ,M.D) and their associates or licensees to take pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes. I additionally consent to the use of any of my medical records including photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

Patient Signature_____ **Date**_____

Witness Signature_____ **Date**_____

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize (Marcus H. Crawford, M.D.& Aisha J. McKnight-Baron, M.D.) and or his associates or licensees to use pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks
(Internet), for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images.

Patient Signature_____ **Date**_____

Witness Signature_____ **Date**_____

Below is list of some of the other services available at Crawford Plastic Surgery

Check any box you'd like more information on during your consultation.

- ☐ Liposuction
- ☐ Breast Augmentation
- ☐ Tummy Tuck
- ☐ Rhinoplasty
- ☐ Facelift
- ☐ Eyelid Surgery
- ☐ Dermal Fillers- Botox, Juvaderm, etc.
- ☐ Aesthetics-Skin Care, Microdermabrasion
- ☐ Permanent Makeup- Eyebrows, Lips, etc.