



The Center for
Plastic Surgery
at Copper Ridge
(231) 929-7700

Today's Date:

Patient Information

Patient First Name, Middle Initial

Patient Last Name

Home Phone Number

Street Address

City/State/Zip

Work Phone Number

Mailing Address, if different from Street Address

City/ State/Zip

Cell Phone Number

Social Security Number

Patient Date of Birth

Single ___ Married ___ Divorced ___ Widowed ___

Patient Employer Name

Email Address (Please only list your email if you are interested in receiving promotional information)

Responsible Party Information – If Different From Patient

Guarantor First Name

Guarantor Last Name

Home Phone Number

Street Address

City/State/Zip

Work Phone Number

Social Security Number

Guarantor DOB

Employer Name

Cell Phone Number

Emergency Contact Information

Emergency Contact Name

Relationship to Patient

Home Phone Number

Contact Home Address

City/State/Zip

Work Phone Number

Cell Phone Number

Appointment Information

Primary Doctor Name

Referring Physician

Reason for this visit

Is this visit related to an Auto or Work Accident?
Auto: Yes _____ No _____ Work: Yes _____ No _____

If yes, what is that date of the injury?

Have you filed claim with your insurance company?
Yes _____ No _____

How did you hear about our office? Please circle all that apply:

Magazine Phone Book Website Radio TV Newspaper

Doctor _____

Friend _____

Other _____

Insurance Information: Primary

Name of Insurance

Subscriber's Name and Relationship to Patient

Subscriber DOB

Contract Number

Insurance Company Phone

Subscriber SS#

Insurance Company Address, City, State, Zip Code

Effective Date Insurance

Insurance Information: Secondary

Name of Insurance

Subscriber's Name

Subscriber DOB

Contract Number

Group Number

Subscriber SS#

Effective Date Insurance

1. All Patients: Please Sign

I hereby authorize the release of medical information to my insurance carrier(s) for payment determination as well as other providers pertinent to my medical care.

I authorize The Center for Plastic Surgery, PC to leave information on my home answering machine or with whoever answers regarding appointment reminders and/or my need to call back.

Further, I authorize The Center for Plastic Surgery, PC to take photographs, pre- and post-treatment, for insurance authorizations and educational purposes.

Patient or Guardian (if under the age of 18 years)

Date

2. Medicare, Worker's Compensation, and Medicaid (age 0-18 years): Please Sign

I hereby authorize my insurance benefits to be paid to The Center for Plastic Surgery, PC for any services rendered to me.

I understand that The Center for Plastic Surgery, PC participates with Medicare. However, if my insurance provider indicates a service to be rendered will not be covered, I will be asked to sign a waiver. This waiver will state my insurance may not cover this service, and I will be fully responsible for payment.

Patient or Guardian (if under the age of 18 years)

Date

3. All Other Insurances: Please Sign

I understand that the providers at The Center for Plastic Surgery, PC only participates with Priority Health, BCBS, BCN Medicare, Worker's Compensation, and Medicaid (age 0-18 years). I authorize The Center for Plastic Surgery, PC to release information to my employer and/or insurance company and to assign benefits incurred to my Doctor. I further understand that the Doctor's fee may exceed what my insurance will pay and that I will be responsible for any balance.

Patient or Guardian (if under the age of 18 years)

Date



The Center for
Plastic Surgery
at Copper Ridge
(231) 929-7700

Today's Date: _____

Review of Systems

Patient Name _____

Patient DOB _____

Age _____

Height _____

Weight _____

Any known allergies? Yes No
Currently taking any medications? Yes No
Previous problems with anesthesia? Yes No

List all medical allergies:

Please explain the reason for your appointment today:

List all of your medications (include supplements):

Please list all surgical procedures performed:

Please indicate if you are currently experiencing or have a history of any of the following conditions:

Weakness Yes No
Fatigue Yes No
Fever Yes No

Nausea/vomiting Yes No
Change in bowel habits..... Yes No
Rectal bleeding..... Yes No
Constipation/diarrhea..... Yes No
Chronic abdominal pain..... Yes No
Jaundice Yes No
Liver trouble Yes No
Gallbladder trouble Yes No
Hepatitis..... Yes No
Ulcers Yes No

Glasses or contact lenses..... Yes No
Change in vision..... Yes No
Pain in eyes..... Yes No
Redness of eyes..... Yes No
Excessive tearing..... Yes No
Double vision Yes No
Glaucoma Yes No
Cataracts..... Yes No
Date of last eye exam: ____ / ____ / ____

Non-healing sores Yes No
Changes in hair and/or nails..... Yes No

Have you had an EKG?..... Yes No
Date of EKG: ____ / ____ / ____
Heart Attack Yes No
High blood pressure Yes No
Heart murmur..... Yes No
Chest pain or discomfort..... Yes No
Irregular heartbeat Yes No

Breast lump Yes No
Breast pain or discomfort Yes No
Nipple discharge..... Yes No
Do you perform breast self-exams?... Yes No
Date of last mammogram: ____ / ____ / ____

Rheumatic fever..... Yes No
Shortness of breath Yes No
Swollen ankles Yes No

Age of first menstrual cycle: ____
Regular menstrual cycles..... Yes No
Number of pregnancies: ____
Number of deliveries: ____

Chronic cough Yes No
Diabetes Yes No
Wheezing Yes No
Asthma Yes No
Bronchitis Yes No
Emphysema..... Yes No
Pneumonia..... Yes No
Tuberculosis..... Yes No
COPD..... Yes No

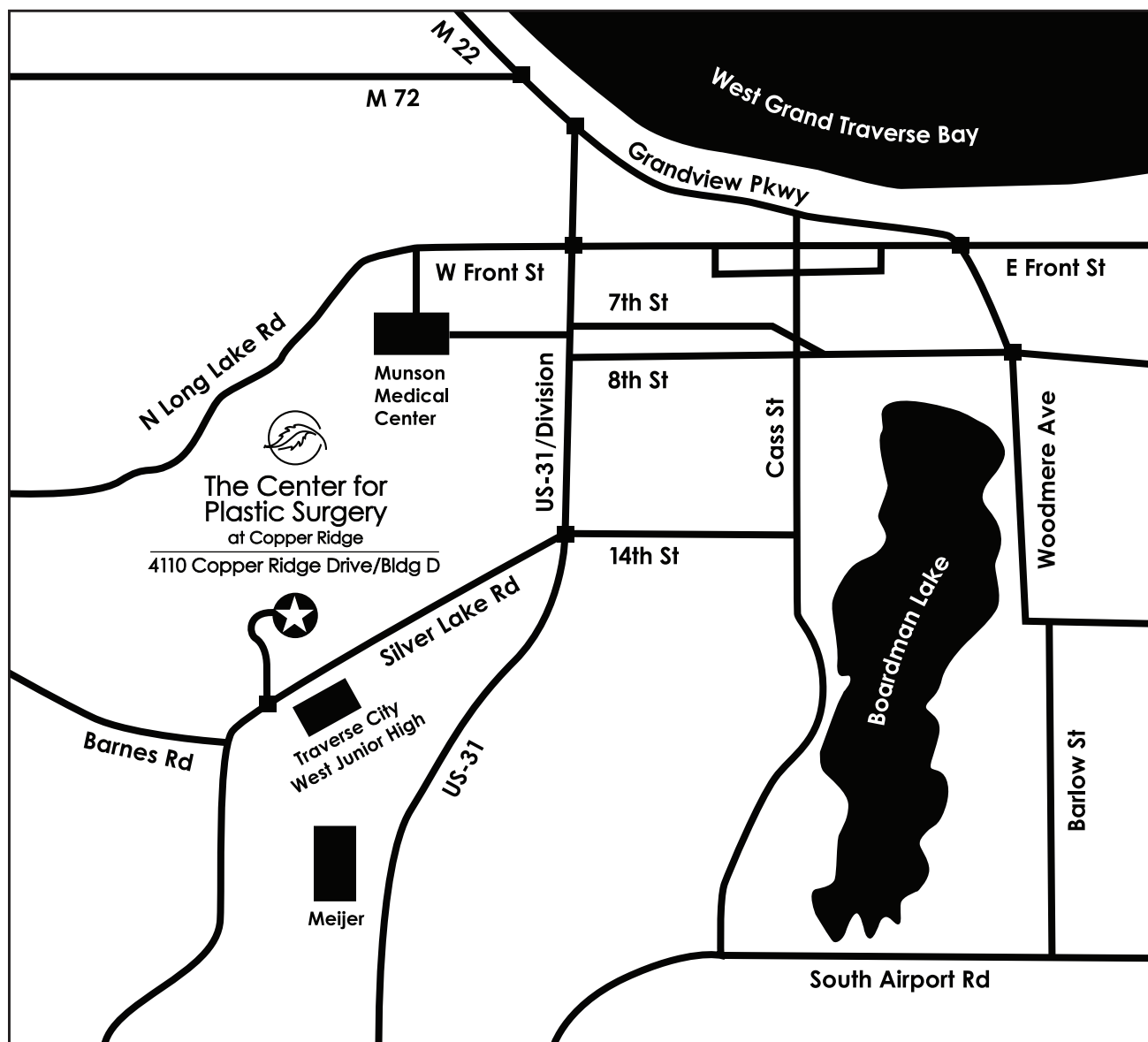
Neurological disorders..... Yes No
Psychiatric disorders..... Yes No
Endocrine disorders..... Yes No
Anemia..... Yes No
Hormonal Disorders..... Yes No

Joint stiffness Yes No
Arthritis Yes No
Gout..... Yes No
Backache..... Yes No

Hearing problems..... Yes No
Tinnitus/ringing in the ears..... Yes No
Dizziness Yes No
Ear infection..... Yes No

Tobacco use..... Yes No How much? _____
Alcohol use Yes No How much? _____
Recreational drug use.. Yes No How much? _____
Caffeine use Yes No How much? _____

The Center for Plastic Surgery



Phone: 231.929.7700
Fax: 231.929.7709
tc-plasticsurgery.com

4110 Copper Ridge Dr
Bldg D, Suite 242
Traverse City, MI 49684

www.tc-plasticsurgery.com