Lexington Plastic Surgery

Theo Gerstle, M.D.

PATIENT INFORMATION (please print) **Date: _____/_____/_____**

☐ He/Him ☐ She/Her

☐ They/Them

Patient Name: _____

Last First M.I.

Address: _____

Street City State Zip

Home phone:(_____) _____ Cellular phone:(_____) _____

E-mail: _____

Sex: M F Birthdate:_____/_____/_____ Soc. Sec. #: _____-_____-_____

(REQUIRED) (REQUIRED)

PROCEDURE(S) of INTEREST: _____

OCCUPATION:

Employer: _____

Employer Address: _____

INSURANCE

Primary Insurance Co: _____

Name of Policyholder/Guarantor: _____

Relation to patient: Self Spouse Parent Other

ID#: _____ Group #: _____

PHARMACY

Name: _____ Phone: _____ City: _____

EMERGENCY CONTACT: _____

Name Relation Phone

Dr. Gerstle is interested in knowing about your general health so he may plan your surgery/treatment as carefully as possible. This form is CONFIDENTIAL.

General health ____ Excellent ____ Good ____ Fair ____ Poor
Marital status ____ Single ____ Married ____ Divorced ____ Widowed

HEIGHT: _____ WEIGHT: _____

1. DRUG ALLERGIES? ____ None If yes, please list medication and reaction.

   Name of Medication Reaction (i.e. nausea, itching, rash, etc)
   1)_____ _____
   2)_____ _____
   3)_____ _____

2. OTHER ALLERGIES? ____ None If yes, please check all that apply.

   ___ Latex ____ Adhesive Tape ____ Contrast Dye ____ Iodine ____ Seafood
   ___ Metal ____ Other, please list _____

3. Any medications, vitamins, over-the-counter herbal preparations/supplements? ____ None
   If yes, please list below.
   Name of Medication Strength (mg) How many times a day? Reason for taking it
   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____

4. Have any family history of cancer, heart trouble, or stroke? Y N (Specify)
   _____

5. Engage in a regular exercise program? Y N (Specify) _____

6. Consume regular amounts of alcoholic beverages? Y N (Amount) _____

7. Use tobacco? Y N (Amount) _____
   Drug Use? Y N (Specify) _____

8. Do you have a skincare regimen? Y N (Product) _____
   _____

9. Have any current or previous use of cortisone/steroids? Y N (List) _____

10. Do you have a problem with general anesthesia? Y N (Specify) _____
    Any family member experienced problem with anesthesia? Y N (Specify) _____
    _____

Please list all surgical procedures you have undergone.

Year	Procedure	Hospital	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please check below:

	Y	N			Y	N	
GENERAL	☐	☐	Serious illness lately?	KIDNEYS	☐	☐	Infections
	☐	☐	Anemia		☐	☐	Kidney damage
	☐	☐	Nervousness		☐	☐	Kidney failure
	☐	☐	Drug habit/addiction				
	☐	☐	Psychiatric treatment	BLOOD	☐	☐	Bleeding tendency
	☐	☐	Blackouts or Epilepsy		☐	☐	Blood transfusions
	☐	☐	Shortness of breath		☐	☐	Blood Clots/DVT
	☐	☐	High blood pressure				
	☐	☐	Diabetes	BREAST	☐	☐	Cyst, tumor, or lump
	☐	☐	Thyroid problems		☐	☐	Breast biopsy
	☐	☐	Susceptible to cold sores		☐	☐	Nipple discharge
	☐	☐	Hidradenitis suppurativa		☐	☐	Mammogram
HEART	☐	☐	Heart trouble	EYES	☐	☐	Visual problems
	☐	☐	Heart attack		☐	☐	Wear contacts
	☐	☐	Palpitations/irregular or extra beats		☐	☐	Wear glasses
	☐	☐	Angina (chest pain)		☐	☐	Use eye drops
	☐	☐	Abnormal EKG		☐	☐	Other (Specify)
	☐	☐	Rheumatic heart disease				
	☐	☐	Heart failure	NOSE	☐	☐	Broken nose
					☐	☐	Difficulty breathing
LUNGS	☐	☐	Asthma				
	☐	☐	Bronchitis		☐	☐	Use nose spray
	☐	☐	Tuberculosis				
	☐	☐	Pneumonia	LIVER	☐	☐	Hepatitis
	☐	☐	Smoker's cough		☐	☐	Cirrhosis (Alcohol Disease)
	☐	☐	Emphysema				
				INTESTINAL	☐	☐	Stomach ulcers
					☐	☐	Colitis
					☐	☐	Gallstones

	Y	N
Do you have an Advanced Directive? If no, would you like a state copy?	☐	☐
Would you like a copy of our Patient Rights and Responsibilities?	☐	☐

Primary Care Physician – Name: _____ Phone Number: _____

Date of your last physical exam: _____
Date of most recent mammogram: _____
Any recent lab work? Y N Date: _____

How did you hear about us: Friend _____
Doctor _____
Facebook/Instagram _____
Internet _____

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POLICIES AND AUTHORIZATIONS RELATED TO PAYMENT

Commercial Insurance

I hereby authorize release of any and all information (including photographs) necessary to file a claim with any insurance company and assign benefits, otherwise payable to me, to the doctor indicated on the claim.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Signature of Policy Holder Date

Payment Policy

All professional services rendered are charged to the patient and are due and payable at the time of service. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, including deductibles and co-payments, regardless of insurance coverage. Past due accounts greater than thirty (30) days will be subject to an interest fee of 1.5% per month. Past due accounts may also be subject to attorney's fees, collection fees, legal fees, and / or court costs incurred as a result of our attempt to collect the debt. A service fee of $25.00 will be assessed for each returned check.

I understand that I am financially responsible for the payment of any amount not covered by my insurance carrier. A copy of this signature is as valid as the original.

_____ _____

Signature of Patient or Personal Representative Date