GEORGE A. TOLEDO, M.D.

Highland Park Plastic Surgery Center

PATIENT INFORMATION

Name _____Cell Phone_____

Address_____ City_____ State_____ Zip_____

Email Address_____ Birthdate_____ Age_____ Sex_____

Ok to call or leave message on your cell phone? Yes_____ No_____ Ok to send email? Yes_____ No_____

Marital Status_____ SS#_____ Driver's License #_____

Employer_____ Occupation_____

Whom May We Contact in an Emergency? _____Phone_____

Who is Responsible for Your Bill? _____

Reason for Consultation_____ How did you hear about us?_____

MEDICAL INSURANCE IF NECESSARY

Insurance Company _____ Phone _____

Insured Name_____

Insured SS#_____ Insured Birthdate _____

Grp#_____ID#_____

ASSIGNMENT OF INSURANCE & CONSENT TO PAY

The Undersigned hereby authorizes and consents to be seen and treated by Dr. George A. Toledo, in addition to the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims or benefits, for services rendered, without obtaining my signature on each and every claim to be submitted by myself and/or dependents, and that I will be bound by this signature as though the Undersigned had personally signed the particular claim. I also authorize payment on my claim, if any, to made directly to George A. Toledo, M.D. and the Highland Park Plastic Surgery Center.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered, and in the event of nonpayment to pay all costs of collection. I have completed the above questions and I certify this information is TRUE and CORRECT to the best of my knowledge. I will notify you of any changes in my health status or the above information.

HEALTH INSUARCE PORTIBILTY AND ACCOUNTABILITY ACT (HIPAA)

I acknowledge I have been presented with a copy of Notice of Privacy Practices for Protected Health Information.

Please sign in office only.

Signature _____**Date**_____

Witness_____ **Date**_____

PATIENT INFORMATION

Height _____ Weight _____(Don't Lie!)

Do you or **did** you smoke, use tobacco or nicotine products? If Yes, how much _____Date Quit_____

Do you use any caffeine products or stimulants -coffee, Diet Coke, tea, diet pills? Yes___ No___
If Yes, which ones _____

Are you **ALLERGIC** to any drugs or medications? Yes___ No___ If Yes, which ones_____

Name of your MEDICAL DOCTOR_____ Phone_____

When was your last complete physical?_____ Results_____

Name of your Pharmacy_____ Phone_____

MEDICATIONS: List all medicines you are now taking (ex: birth control, diuretics (water pills), blood pressure or heart meds, tranquilizers, hormones, cortisone, blood thinners, aspirin, etc.) Include any diet pills, vitamins, herbal, or homeopathic

_____

	Yes	**No**
Have you ever had a REACTION to a GENERAL anesthesia (being put to sleep)?	○	◉
Have you ever had a REACTION to a LOCAL anesthesia (Novocaine, etc.)?	○	◉
Do you scar poorly (keloid, hypertrophic scars)?	○	◉
Do you bruise easily or have difficulty stopping bleeding when cut?	○	◉
Have you ever had any significant emotional problems or required psychiatric care?	○	◉
Have you seen other plastic surgeons for your current problem?	○	◉

MEDICAL ILLNESS: List all diseases or illnesses you have had, (ex: high blood pressure, diabetes, heart or lung problems, etc.) and state how they are being treated.

_____

_____

INJURIES: Are you here today because of an accident? DATE_____ TYPE_____

PREVIOUS HOSPITALIZATION and/or SURGERY (especially any type of **COSMETIC SURGERY):**

Date_____ Procedure_____

Date_____ Procedure_____

Date _____ Procedure_____

MATERNAL HISTORY: How many children do you have? _____ Could you be pregnant now? _____

FAMILY HISTORY: Has a family member had?
Heart Disease _____ Breast Cancer_____
Melanoma/Skin Cancer_____ Other_____
Any **OTHER** information which may assist us in your care _____

_____

SIGNATURE _____

Relationship to Patient (Self, Mother Etc.) _____