JOHN B.FASANO, MD PLASTIC AND RECONSTRUCTIVE SURGERY

MEDICAL INFORMATION

Today's Date:_____Reason for today's visit:_____

If an accident, where did it occur? Work_____Home_____Other_____ State_____

Have you seen any other physician for this problem? _____

DRUG ALLERGIES: _____

MEDICATIONS: PLEASE LIST ALL MEDICATIONS YOU CURRENTLY TAKE ON A REGULAR BASIS_____

_____

Height _____Weight _____ Bra Size _____

DAILY INTAKE: Tobacco_____Alcohol_____Coffee_____Aspirin_____Insulin_____Steroids_____

MEDICAL HISTORY: DIABETES_____PACEMAKER_____HEPATITIS_____HIGH BLOOD PRESSURE_____

ARTIFICIAL JOINT (S) _____PROLONGED BLEEDING _____ BLOOD TRANSFUSIONS _____

MITRAL VALVE PROLAPSE_____ PREGNANT _____ HISTORY OF MRSA _____

Please list all medical problems, past and present:_____

_____

_____

Is there any significant family history of medical problems ?_____

SURGICAL HISTORY: PLEASE LIST ALL OPERATIONS AND YEAR

_____

_____

HAVE YOU OR ANYONE IN YOUR FAMILY EVER HAD A BAD REACTION TO LOCAL OR GENERAL ANESTHETIC?_____

Who is your primary physician?_____Phone: _____

Assignment of Benefits / Consent for Treatment / Release of Medical Information

I hereby authorize payment to be made directly to John B Fasano, Md of all benefits payable to me under the terms of my insurance contract with respect to professional services, including authorized Medigap benefits. Our office charges $25.00 for any returned check. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. I also understand that I am financially responsible for any outside laboratory services rendered; this applies to any services that are not covered by my insurance company. This assignment will remain in effect unit revoked by me in writing, and I permit a copy of this authorization to be used in place of the original. I further authorize the release of any pertinent medical information regarding services rendered.

Patient Signature:_____Date:_____

(Parent must sign if patient is a minor)