Daniel A. Sterling, MD, FACS

Sterling Plastic Surgery, PLLC
2 Washington Place
Bedford, NH 03110
PH: (603) 518-5450/ Fax: (603) 518-5856

PATIENT INFORMATION

*Please **PRINT** and complete **BOTH** sides of all forms in packet.*

Legal Name________________________________ Nickname _____________ Age____ D.O.B.__________
First Middle Last

Today's Date_________________ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widow
Mailing address______________________________ City________________ State________ Zip_________
Home telephone___________________________ Work telephone___________________ Ext_________
Cell phone________________________________ Social Security Number________________________
Email____
Parent/guardian ____________________ Relationship to Patient ___________ Phone number__________
How did you hear about us? ☐ Website ☐ Referral ____
Can we email you with updates and promotions? ☐ Yes ☐ No

Reason for Consult ____

Your occupation_________________________________ Employer________________________________
Business address____ Phone number___________________

IN CASE OF EMERGENCY, CONTACT: (PLEASE PRINT ALL INFORMATION)

________________________________ Relationship to patient_______________ Phone _________________
________________________________ Relationship to patient_______________ Phone _________________

REFERRING PHYSICIAN____ Phone ____________________
Street ____
City ____ State _____________ Zip _____________

MEDICAL PERMISSION: It is strongly recommended that you allow us to stay in contact with your primary care medical provider both before and after your surgery. This will help make your surgery safe, and will help maintain complete medical records which are important for your physician. For patients having breast implants, you may prefer that we stay in contact with your OB-GYN doctor. We are happy to maintain communication with more than one doctor and all correspondence is confidential.

Physician #1 ____ Phone _______________________
Street ____ Fax _________________________
City ____ State _____________ Zip _____________

Physician #2 ____ Phone _______________________
Street ____ Fax _________________________
City ____ State _____________ Zip _____________

X____ ____________________
Patient signature for permission to contact doctors Date

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MEDICAL INFORMATION

Patient Name: __________________ **Height: _________**
Patient DOB: __________________ **Weight: _________**

Past Medical History: (please check all that apply) **None** ( )

( ) COPD/Emphysema	( ) Other heart problems	( ) Kidney disease
( ) Asthma	( ) PVD	( ) GI disease
( ) Sleep Apnea	( ) Hypertension	( ) MRSA/VRE
( ) Tuberculosis	( ) Anemia	( ) AIDS/HIV
( ) Thyroid disease	( ) Bleeding disorder	( ) Herpes/Cold sores
( ) Heart Attack	( ) Bruise easily	( ) Cancer/Malignancy
( ) Stroke/TIA	( ) DVT/PE (blood clot)	( ) Depression/Anxiety
( ) Stent Placement	( ) Diabetes	( ) Multiple Sclerosis
( ) A-Fib	( ) Liver disease	( ) Seizure disorder

Other/Clarification:____
____

Past surgical history (please check all that apply) **None** ( )

( ) Angioplasty	( ) Thyroidectomy	( ) Bowel resection
( ) Heart Stents	( ) Tonsillectomy	( ) Hernia Repair
( ) Heart Bypass	( ) Appendectomy	( ) C-Section
( ) Heart Valve	( ) Gallbladder	( ) Hysterectomy
( ) Pacemaker/Defibrillator	( ) Gastric Bypass	( ) Breast Surgery

Other/Clarification:____
____

	Yes	**No**	**Comments**
Anesthesia complications	( )	( )	______________________________
Post-op nausea or vomiting	( )	( )	______________________________
Surgical complications (ex: bleeding / infection)	( )	( )	______________________________

Pharmacy __________________ Address ________________________ Phone number ________________

Current Medication **Dose** **Prescribed By**

____
____
____
____

Vitamins / supplements / herbals

____
____

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MEDICAL INFORMATION (continued)

Patient Name: ________________
Patient DOB: ________________

Allergies to medications: (please list below) **No Known Drug Allergies** ( )

Medication(s)/ Reaction
____
____
____

	Yes	No	Reaction
Iodine/Shellfish	( )	( )	_________________________
Latex	( )	( )	_________________________
Adhesives/Tape	( )	( )	_________________________

Other (ex: food allergies, environmental): ____

Family History (please check all that apply) **None** ( )

( ) Diabetes	( ) Cancer	( ) DVT/PE
( ) Heart Disease	( ) Bleeding disorder	( ) Stroke
( ) CVA/Stroke	( ) Anesthesia complication	( ) Anemia

Other/Clarification: (ex. Breast cancer, etc.)
____
____

Social history:	Yes	No	
Do you smoke?	( )	( )	If yes, how many packs per day? ____ For how many years? ____
Hx of nicotine use?	( )	( )	If yes, how long did you use nicotine? __ When did you quit? ____
Do you drink alcohol?	( )	( )	If yes, how many alcoholic beverages per week? ____
Recreational drug use?	( )	( )	

Procedures you are interested in: ____
____

Questions we should discuss:
____
____
____

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Authorization to Discuss Information

I hereby authorize Sterling Plastic Surgery, PLLC to disclose the specific information as follows:

Description of the specific information to be discussed:

□ Appointment Date/Times □ Medical Information □ Financial Information

□ Other (specify): ____

Indicate Confidential Information (specify):____

Patient Name: ____
(please print)

Date of Birth: ___________________

Information to be given to i.e. significant other, family member etc. If no one please write <u>NONE</u> and sign and date form.

Name: ____
(please print)

Relationship: ____

Address: ____

Phone: ____

This authorization shall remain in effect from the date signed below until (please check one):

□ _____________________________ (specify expiration date)

□ NO EXPIRATION DATE

I understand that:

- I may revoke this authorization in writing by contacting your office, attention Administrator.
- This authorization is giving Sterling Plastic Surgery, PLLC the right to discuss my medical information and/or financial information with the person listed above. A separate form needs to be completed for each individual.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.

____ Date: ________________________

Signature Patient or Person Authorized to Sign for Patient

____

Print Patient or Person Authorized to Sign for Patient

Relationship to Patient: _______________