Garcia Plastic and Hand Surgery

First Name_____MI___Last_____Date_____

Address_____City_____State____Zip Code_____

Home Phone_____Cell_____Work_____

DOB_____ Age____ Sex: _____ Email_____

Employer_____Occupation_____

Employer's Address_____

Which provider requested this consultation_____

Primary Care Physician_____Phone_____

Cardiologist_____Phone_____

Emergency Contact Name_____Relationship to you_____

Home Phone_____Cell_____Work_____

Address_____City_____State____Zip Code_____

Employer_____ Employer's address_____

Do you have a **Health Care Proxy (HCP):**Yes / No Name on HCP_____

Insurance Information

Primary Insurance plan_____ ID#_____

Subscriber's Name_____ DOB_____

Secondary Insurance plan_____ ID#_____

Subscriber's Name_____ DOB_____

Is this a worker's compensation claim? yes or no

The office is connected to SureScripts information system to obtain your current medications. By signing this, you certify the information on this form is correct, you agree to the exchange of medical information between SureScripts and your providers.

Signature of Patient or Patient's Representative_____

Relationship to patient_____ Today's date_____

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Name_____DOB_____Weight_____Height____
Allergy_____Reaction_____Allergy_____Reaction_____

Medication_____
_____
_____
_____
_____

Medical History (Circle if yes)
History of skin cancer: **Melanoma / Squamous cell carcinoma / Basal cell carcinoma**

Anemia	High blood pressure	Autoimmune disease_____
Asthma	High Cholesterol	Bleeding or clotting disorders_____
Emphysema	Coronary Artery Disease	Cancer_____
COPD	Heart Murmur	Sleep Apnea CPAP or BIPAP
Anxiety	Abnormal EKG	Diabetes: oral / insulin
Gout	AFIB / SVT	Chronic kidney disease: Stage 1 2 3 4
Liver disease	Pacemaker	Dialysis / fistula Right or Left
Prostate disease	AICD defibrillator	Arthritis_____
Reflux/ GERD	Stroke / heart attack	MRSA / ESBL / VRE
Multiple Sclerosis	Parkinson's	HIV / AIDS
Other_____	Dementia / Alzheimer's	Hepatitis A / B / C

History of Cardiac surgery_____
History of joint replacments_____
History of any other surgeries/hospitalizations_____

Hand Dominance: (Circle one) Right hand / Left hand / Ambidextrous

Tobacco: Never used/smoke Previous **User Date Quit**____ Current Smoker: # cig/pipe/chew per day____

Drinking: No Alcohol use Alcohol Use # of Drinks/Day_____

How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? _____

Recreational Drugs: Any current use: **YES or NO** Past use: **YES or NO** Drug type:_____

Family History (Circle if yes)

Cancer	High Blood Pressure	Diabetes
Stroke	Heart Disease	Kidney Disease

Pharmacy_____Address_____

Do you have a **Health Care Proxy (HCP)**: Yes or No Name on HCP_____
Relationship_____ Date effective_____