LAUGHLIN
Plastic Surgery

Laughlin Plastic Surgery, LLC
166 Defense Highway, Suite 101
Annapolis, MD 21401
410-224-2020

Name: _____ Age: _____ Date of Birth: _____Sex: F M

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ SS#: _____

Street Address: _____ City: _____ Zip: _____

Reason for Today's visit: _____How did you hear about us? _____

Marital Status: Single Married Divorced Widowed

Emergency Contact: _____Relationship: _____Phone: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Employer: _____ Occupation: _____

Did you receive a copy of the HIPPA notice? Yes ____ No____ Do you give permission to leave a voicemail? Yes ___ No ____

Insurance Info:

Primary Health Insurance: _____ ID#: _____

Group#: _____ Subscriber: Self _____ Spouse _____ Other _____

Subscriber's Name: _____ DOB: _____

Secondary Health Insurance Name: _____ ID#: _____

Group #: _____ Subscriber: Self _____ Spouse _____ Other _____

Subscriber's Name: _____DOB: _____

All patients are required to complete our registration form, provide us with a valid medical insurance card and a photo ID, as well as new insurance cards as they become available. We accept assignment of insurance benefits as a courtesy to our patients; however the balance is your responsibility. Deductibles applied by your insurance, not covered by another insurance, will also be your responsibility. Please be aware that some services provided may not be covered and may not be considered medically necessary, under Medicare and other insurances. Patients will be responsible for payment in full at the time of visit, unless valid insurance is presented. All copayments are to be paid at the time services rendered.

I HAVE CAREFULLY READ AND UNDERSTAND AND AGREE TO THE OFFICE POLICY OF LAUGHLIN PLASTIC SURGERY, LLC.

Medical History Questionnaire
(Confidential Information)

Patient's Name: _____ Date: _____

Reason for Visit: _____

Height: _____ Weight: _____

Do you smoke or use any nicotine replacement product? _____ If so, how much per day? _____

Medical History: Please check the following

High Blood Pressure……yes____no____

Bleeding Disorder…….yes____no____

Anemia…….yes____no____

Liver Disease…….yes____no____

Heart Disease……yes____no____

Psychiatric Illness……yes____no____

HIV…….yes____no____

Skin Disease……..yes____no_____

Thyroid Disease……..yes____no_____

Lung Disease…….yes____no_____

Tuberculosis……..yes____no_____

Shortness of Breath..yes____no_____

Hepatitis……yes____no_____

Diabetes…….yes____no_____

Please list any other medical history the doctor should be aware of:

_____

Please list all previous surgeries, as well as cosmetic:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Please list any complications or problems you experienced during or following the above procedures:

_____

Family History: (serious illnesses; cancer, etc)

_____

Medical History Questionnaire (cont'd)
(Confidential Information)

MEDICATIONS: Please list medications you currently take, including appetite suppressants, vitamins, etc.

_____

_____

Do you take any Aspirin or any Aspirin-containing compound? _____If yes, explain below:

_____

_____

Do you have any **ALLERGIES and/or SENSITIVITIES** to the following medications:

Penicillin……..yes_____no_____

Sulfa……yes_____no_____

Codeine……yes_____no_____

Latex……..yes_____no_____

Other Antibiotics (list)……yes_____no_____

_____

Aspirin……..yes_____no_____

Xylocaine…….yes_____no_____

Adhesive tape……..yes_____no_____

Tetanus Toxix……yes_____no_____

Any other allergies not listed above: _____

_____

Do you wear eyeglasses or contacts? _____

Primary Physician: _____ Date of last check-up? _____

Phone #: _____