Randy Tate, M.D.
CENTRE FOR FACIAL PLASTIC SURGERY

Please fill out all information as completely as possible. This information will help us in processing your office visit and make your visit a smoother, quicker and more efficient process.
Thank you!

PATIENT INFORMATION

Name: ______ Date of Birth: ______ Height: ______ Weight: ______

Address: ______ Sex: ______ Age: ______ Marital Status: ______

City: ______ State ______ Zip: ______ SSN ______

Home Phone: ______ Work Phone: ______ Cell Phone: ______

Employer: ______ Occupation: ______

Spouse Name: ______ SSN ______ Date of Birth: ______

ADDITIONAL INFORMATION

What is the chief complaint that brought you to the doctor's office:

______

Who referred you to our office? ______

Who is your Primary doctor? ______

Pharmacy Name: ______ Pharmacy Location: ______

Email Address: ______ ***(For Medical Records purposes)***

Would you like to be added to our VIP email list to be notified of exclusive events and promotions? ☐ Yes ☐ No

Are you interested in talking to our Esthetician about skin care treatments or products? ☐ Yes ☐ No

INSURANCE INFORMATION

*** Please give cards to receptionist ***

Primary Insurance: ______ ID#: ______

Subscriber (Who Carries Insurance): ______

Secondary Insurance: ______ ID#: ______

Subscriber (Who Carries Insurance): ______

EMERGENCY CONTACT

Person to notify *(in case of emergency)*: ______ Relationship: ______

Phone # ______

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Centre for Facial Plastic Surgery to release any information required to process my claims.

______
Patient Name: Date ______

MEDICAL HISTORY/INFORMATION

Medication Allergies:	Reactions:	Severity:	Adult or Childhood Onset?

Are you allergic to Latex? ☐ Yes ☐ No

Current Medical Problems *(i.e. Diabetes, Heart Disease)*: ____________________

____

____

MEDICATIONS

Name:	Dosage:	Name:	Dosage:

Do you take aspirin/ibuprofen/Motrin on a daily basis? ☐ Yes ☐ No

SURGERY/HOSPITALIZATIONS

Procedure:	Date:

SOCIAL HISTORY

Do you currently smoke? ☐ Yes ☐ No How many per day: ________ How many years: ________

If no, have you smoked in the past? ☐ Yes ☐ No Date you quit: ____________

Do you currently drink alcohol? ☐ Yes ☐ No How many per day: ________ Do you use Recreational Drugs? ☐ Yes ☐ No

Occupation: ____________________ Are you retired? ☐ Yes ☐ No

FAMILY HISTORY

Are there diseases that run in your family? ☐ Yes ☐ No

Relationship:	Disease:

____
Patient Name:

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD

RESPIRATORY:

Daily chronic cough	◯ Yes	◯ No	◯ Don't Know
Sputum, phlegm or mucus production	◯ Yes	◯ No	◯ Don't Know
Asthma, wheezing	◯ Yes	◯ No	◯ Don't Know
Bronchitis, Emphysema, COPD	◯ Yes	◯ No	◯ Don't Know
Tuberculosis (TB)	◯ Yes	◯ No	◯ Don't Know
Can you walk 2 flights of stairs without stopping to catch your breath?	◯ Yes	◯ No	◯ Don't Know

CARDIOVASCULAR:

Chest pain, angina, heart attack	◯ Yes	◯ No	◯ Don't Know
Leg swelling, CHF	◯ Yes	◯ No	◯ Don't Know
Asthma, wheezing	◯ Yes	◯ No	◯ Don't Know
Shortness of Breath	◯ Yes	◯ No	◯ Don't Know
High Blood Pressure, Hypertension	◯ Yes	◯ No	◯ Don't Know
Heart Murmur, rheumatic fever	◯ Yes	◯ No	◯ Don't Know
Cramping in legs when walking	◯ Yes	◯ No	◯ Don't Know
Phlebitis (blood clots)	◯ Yes	◯ No	◯ Don't Know
Do you sleep on more then 2 pillows?	◯ Yes	◯ No	◯ Don't Know
Do you wake up short of breath?	◯ Yes	◯ No	◯ Don't Know

ENDOCRINE:

Diabetes, high/low blood sugar	◯ Yes	◯ No	◯ Don't Know
Thyroid problems, heat or cold tolerance	◯ Yes	◯ No	◯ Don't Know

HEMATOLOGIC:

Bleeding Problems	◯ Yes	◯ No	◯ Don't Know
Anemia	◯ Yes	◯ No	◯ Don't Know

DERMATOLOGIC:

Skin Cancer	◯ Yes	◯ No	◯ Don't Know

GASTROINTESTINAL:

Hiatal hernia, heartburn	◯ Yes	◯ No	◯ Don't Know
Ulcers, vomiting blood	◯ Yes	◯ No	◯ Don't Know
Hepatitis, jaundice	◯ Yes	◯ No	◯ Don't Know
Liver disease, cirrhosis	◯ Yes	◯ No	◯ Don't Know

GENITOURINARY:

Could you be pregnant?	◯ Yes	◯ No	◯ Don't Know
Difficulty passing urine	◯ Yes	◯ No	◯ Don't Know
At risk for AIDS or VD	◯ Yes	◯ No	◯ Don't Know

MUSCULOSKELETAL:

Physical limitations or prosthesis	◯ Yes	◯ No	◯ Don't Know
Arthritis	◯ Yes	◯ No	◯ Don't Know

Patient Name: ______________________

NEUROLOGICAL/PSYCHIATRIC:

Depression	◯ Yes	◯ No	◯ Don't Know
Seizures, convulsions, fainting, epilepsy	◯ Yes	◯ No	◯ Don't Know
Stroke, fleeting blindness, weakness	◯ Yes	◯ No	◯ Don't Know
Paralysis	◯ Yes	◯ No	◯ Don't Know
Psychiatric Treatment	◯ Yes	◯ No	◯ Don't Know

GENERAL:

Headaches, unexplained weight loss or fatigue	◯ Yes	◯ No	◯ Don't Know
Cold Sores	◯ Yes	◯ No	◯ Don't Know

Other ____________________

ACKNOWLEDGMENTS

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I AGREE TO THE FINANCIAL POLICY FOR DR. RANDY TATE OFTHE CENTRE OF FACIAL PLASTIC SURGERY.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE"NOTICE OF PRIVACY PRACTICES" (HIPPA) FROM DR. RANDY TATE'S OFFICE.

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I UNDERSTAND DR. RANDY TATE IS LICENSED BY THE MEDICALBOARD OF CALIFORNIA.

____

Patient Signature:

Date: ____________________

____

Patient Name: