Donald R. Collins, Jr., M.D., F.A.C.S.

Aesthetic Plastic Surgery

Name ______________________________
Last First Middle

Address ______________________________
Street & Apt # City State Zip

Home Phone ______________ Cell Phone ______________ Other Phone ______________

Any restrictions for contacting you? ❒ No ❒ Yes E-mail ______________

Contact Restrictions: ______________ ______________

Age ________ Birthdate / / SS# - - ❒ Female ❒ Male

Marital Status ________ Referred By ______________ Family Physician ______________

Employer ______________ Occupation ______________

Work Phone ______________ Ext: ________ Is it okay to call you at work? ❒ Yes ❒ No

Address ______________________________
Street & Suite # City State Zip

Emergency Contact ______________ Relationship to Patient ______________

Home Phone ______________ Work Phone ______________ Other Phone ______________

Address ______________________________
Street & Apt # City State Zip

Primary Health Insurance Company ______________________________

Policy # ______________ Group # ______________ Ins. Phone ______________

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ ________

Insured: Name ______________ DOB ______________ Employer ______________

Secondary Health Insurance Company ______________________________

Policy # ______________ Group # ______________ Ins. Phone ______________

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ ________

Insured: Name ______________ DOB ______________ Employer ______________

I understand that office visit charges are payable on the day service is rendered. I authorize Donald R. Collins, Jr., M.D. to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Donald R. Collins, Jr., MD and myself. I verify that all of the information on this form is complete and accurate.

Signature ______________________________ **Date** ______________

Medical Information

Patient Name ______________________________

Reason for Consultation______________________________

____

Height____________ Weight____________ Age____________

Serious Illnesses______________________________

____

____

Previous Surgeries______________________________

____

____

Current Medications______________________________

____

Drug Allergies______________________________

____

Pharmacy______________________________ Phone____________

Hereditary Disorders (Diabetes, Cancer, Hypertension, Heart Disease)____________

____

____

Do you take aspirin? ☐ No ☐ Yes How Often? ____________

Do you smoke? ☐ No ☐ Yes How long and how much?____________

Do you drink? ☐ No ☐ Yes How long and how much?____________

Do you or have you used illicit drugs? ☐ No ☐ Yes How long and how much?____________

If there is any additional information relevant to your medical history that you feel is important, please explain______________________________

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