



Acct. # _____

New Patient Information (Please Print)

Date: _____

NAME		DATE OF BIRTH	AGE	SOCIAL SECURITY #		MARITAL STATUS S M D W SEP	
STREET ADDRESS		CITY AND STATE		ZIP CODE	HOME PHONE # with area code		
EMPLOYER					BUSINESS PHONE # with area code		
OCCUPATION					CELL PHONE # with area code		
SPOUSE		SPOUSE'S EMPLOYER/OCCUPATION			SPOUSE CELL PHONE # with area code		
EMERGENCY CONTACT							
STREET ADDRESS		CITY, STATE AND ZIP		HOME PHONE # ()		CELL PHONE #	
HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S)?						YES	NO
REFERRAL SOURCE (PLEASE FILL IN)		SEND THANK YOU?	STREET ADDRESS, CITY, STATE, & ZIP				

Email address: _____

Patient's or authorized person's signature is required. (Please read and sign.)

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for surgical procedures in advance and other services when rendered unless other arrangements have been made in advance. Dr. Branman does not participate in Medicare and/or Medicaid.

I hereby authorize Dr. Branman to furnish all of my medical chart information to my insurance carrier (including, but not limited to any protected patient information, such as drug use, alcohol use, mental health records, psychiatric treatment, HIV status, or other specially protected information) concerning my treatment. I agree that I will not record, in any way, anything, which occurs in the office of Dr. Branman without prior written consent.

A doctor-patient relationship is a consensual agreed upon contractual relationship between Dr. Branman and me. Either party can agree or disagree to enter into a doctor-patient relationship. I agree that no doctor-patient relationship will be established between Dr. Branman and me until Dr. Branman has administered a definite treatment procedure to me. I agree a definite treatment procedure by definition is limited to: therapeutic injections, chemical peels, laser treatments, or direct surgical intervention. I further agree that my office consultation, surgical fee deposit, or scheduling of surgery does not constitute a definite treatment procedure or a doctor patient relationship. I agree that Dr. Branman may cancel at will any office or surgical appointment without notice or cause.

Signature _____

Date _____



Health History Questionnaire

Date _____

Patient Name _____

E-mail _____

Date of Birth _____ Age _____ Height _____ Weight _____

Family Physician _____ Phone _____ City / State _____

Do we have permission to obtain additional health information from your family physician? Yes No

When was your last physical examination? _____

Do you have any allergies to medications, iodine or tape? Yes No If yes, please list

Are you allergic to Latex? Yes No

Are you currently taking any medications? Yes No
If yes, please list _____

Do you take any Herbal or nutritional supplements? Yes No
If yes, please list _____

Are you currently taking aspirin, ibuprofen, birth control pills or weight loss medication? Yes No
If yes, please list. _____

Have you had previous cosmetic, plastic or reconstructive surgery? Yes No

What type of surgery? _____

Date _____

By whom? _____

Have you ever had any other type of surgery? Yes No

Type of surgery _____ Date _____

Did you experience any complications? Yes No

If yes, please specify _____

Do you currently smoke cigarettes or use tobacco products? Yes No

If yes, how much per day? _____ For how long? _____

If you previously smoked how much and when did you quit?

Have you ever experienced an adverse reaction to general anesthesia or IV Sedation? Yes No

If yes, please describe the type of reaction _____

Have you ever had problems with local anesthesia (Novocain, Xylocaine, etc)? Yes No

Do you have a history of excessive or spontaneous bleeding? Yes No

If yes, please specify _____

Have you ever had a blood transfusion? Yes No If yes, when? _____

Do you drink more than 6 cups of coffee per day? Yes No

Do you normally have more than 2 drinks of alcohol per day? Yes No

Have you ever been under the care of a psychologist or psychiatrist? Yes No

If yes, please explain. _____

PLEASE CHECK ALL BOXES

- | | | | |
|----------------------------|--|--------------------------------------|--|
| Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | High / Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nasal Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS or positive HIV test | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hospitalization for Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Vision / Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Decreased circulation (fingers/toes) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pains | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stomach Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Irritations | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lung Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes or fever blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gall Bladder Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually Transmitted Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis/Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Severe Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur / Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dizzy Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | Autoimmune Disease (Lupus, MS) | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Paralysis/Numbness Yes No
Bruise Easily Yes No
Heart Attack/Arrhythmia Yes No
Stroke Yes No
Cancer Yes No

MRSA or Staff Infection Yes No
Alcohol abuse Yes No
Drug abuse Yes No
Blood Clot / Pulmonary Embolism Yes No
Other Yes No

Yes No
 Yes No
 Yes No
 Yes No
 Yes No

If you answered yes to any of the above, please explain and list medications that are being used to treat the condition

WOMEN

Is there a history of breast cancer in your family?

Yes No

If yes, please specify

MOTHER'S SIDE: __yes __no
__mother __sister
__grandmother __aunt

FATHER'S SIDE: __yes __no
__mother __sister
__grandmother __aunt

Have you ever had a mammogram? Yes No If yes, date of last mammogram _____

Are you pregnant or trying to become pregnant? Yes No

Do you have heavy menstrual periods? Yes No

When was the first day of your last period? _____

Number of children _____ Number of pregnancies _____

Number of children breast fed _____ Date of last breast feeding _____

MEN

Have you ever had prostate problems?

Yes No

Do you use sexual performance drugs such as Viagra, Levitra, Cialis, etc.? Yes No

Patient's signature _____ Date _____

Physician signature _____ Date _____

Preferred Contact Methods To Assure Patient Privacy

I wish to be contacted in the following manner (CHECK ALL THAT APPLY)

Home Telephone _____

O.K. to leave message with detailed information (such as appointment time and reason)

Leave message with call-back number only

Work Telephone _____

O.K. To leave message with detailed information (such as appointment time and reason)

Leave message with call-back number only

Cellular Telephone _____

O.K. to leave message with detailed information (such as appointment time and reason)

Leave message with call-back number only

Written Communication

O.K. to mail to my home address

O.K. to mail to my work/office address

O.K. to fax to this number _____

O.K. to email to this email address _____

O.K. to text to my cell phone _____

Patient Signature _____ **Date** _____

Patient Name (print) _____