BERKS PLASTIC SURGERY
PATIENT REGISTRATION FORM

Patient's Name: _____ Sex: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Last FOUR digits of Social Security Number: _____ Date of Birth: _____ Age: _____

Current Height: _____ Current Weight: _____ Family Doctor: _____ Phone: _____

If a minor, give parents and/or legal guardian's names: _____

Minor resides with: _____

**NOTE: Custodial Parent/Guardian receives all correspondence and billing information from this office.

Person to Contact in Case of Emergency: _____ Phone Number: _____

Spouse's Name: _____ Spouse's Phone Number: _____

How did you hear about us? *(Check one)* □ Yellow Pages □ Internet □ Billboard □ Other: _____

Referred By: _____ Phone Number: _____

Please complete ALL of the following forms in full:

SOCIAL HISTORY

Tobacco Use: □ Never □ Previous *(quit date)*: _____ □ Current *(how often)*: _____

Are you exposed to passive (secondhand) smoke?

□ Yes, outdoors only □ No □ Minimal □ Frequent □ Daily

Alcohol Use: □ No History of alcohol use □ History of alcoholism

□ History of alcohol use *(if you select this option, please choose **ONLY ONE** of the options below)*

Glasses **daily:** □ <1 □ 1 □ 2 □ 3 □ 4 □ 5+

Glasses **weekly:** □ 1 □ 2-5 □ 6-10 □ 11-15 □ 16-20 □ 21+

Glasses **occasionally:** □ Socially □ Once a Month □ On Holidays

Drug Use: □ No history of drug use □ History of drug use *(please choose **ONLY ONE** bubble for each item below)*

IV drug use: □ None □ Past □ Current

Marijuana: □ None □ Past □ Current

Crack/Cocaine: □ None □ Past □ Current

FAMILY MEDICAL HISTORY

Please indicate which family member(s) have had these illnesses:

□ **Family History UNKNOWN** □ **ADOPTED** □ **NO SIGNIFICANT FAMILY MEDICAL HISTORY**

	Father	*Mother*	*Brother*	*Sister*
Anemia	□	□	□	□
Breast Cancer	□	□	□	□
History of Blood Clots/DVT	□	□	□	□
Cirrhosis of the Liver	□	□	□	□
Crohn's Disease	□	□	□	□
Diabetes	□	□	□	□
History Bleeding Disorders	□	□	□	□
Heart Disease	□	□	□	□

	Father	*Mother*	*Brother*	*Sister*
Hepatitis C	□	□	□	□
Ovarian Cancer	□	□	□	□
Pancreatitis	□	□	□	□
Peptic Ulcer Disease	□	□	□	□
Ulcerative Colitis	□	□	□	□
Basal Cell Carcinoma	□	□	□	□
Squamous Cell Carcinoma	□	□	□	□
Melanoma	□	□	□	□
Cancer: TYPE _____	□	□	□	□

MEDICATIONS AND ALLERGIES

Please list, or provide a copy, of all medications you are currently taking including prescriptions, over-the-counter medications, vitamins, herbs, supplements, etc.:

☐ I AM NOT CURRENTLY TAKING ANY MEDICATIONS ☐ SEE ATTACHED LIST

Medication / Supplement	Dosage	Frequency	Reason for Taking

Local Pharmacy (name, location, phone #, etc.): _____

Please list all items you are allergic to. *Include medications, environmental (dander, pollen, etc.) and food allergies.*

☐ I HAVE NO KNOWN ALLERGIES

Allergen	Reaction	Allergen	Reaction

PAST MEDICAL HISTORY

*Please indicate if **YOU** have a history of the following:*

PSYCHOLOGICAL ☐ Anxiety ☐ Depression ☐ Obsessive Compulsive ☐ Schizophrenia ☐ **No past history**

NEUROLOGICAL ☐ Migraines/ Headaches ☐ MS (Multiple Sclerosis) ☐ Dementia ☐ Parkinson's
☐ TIA (mini stroke) or Stroke ☐ Myasthenia Gravis ☐ Alzheimer's ☐ Seizure Disorder
☐ Brain Aneurysm ☐ **No past history**

RENAL (KIDNEY) DISEASE ☐ Bladder Disease ☐ Dialysis ☐ Kidney Failure ☐ Kidney Stones
☐ **No past history**

ENDOCRINE/METABOLIC ☐ Type 1 Diabetes Insulin Dependent ☐ Type 2 Diabetes Non-Insulin Dependent ☐ Thyroid Disease ☐ **No past history**

BLOOD RELATED PROBLEM ☐ History of Blood Clots/DVTs ☐ History of Blood Disorder
☐ Hemophilia ☐ Bleeding/Clotting Problems
☐ Sickle Cell Disease ☐ Anemia ☐ **No past history**

SKIN PROBLEMS ☐ MRSA ☐ VRE ☐ Eczema ☐ Psoriasis ☐ Melanoma
☐ **No past history**

CARDIOVASCULAR ☐ Elevated Cholesterol ☐ Hypertension (High Blood Pressure) ☐ Endocarditis
☐ Abdominal Aneurysm ☐ Heart Valve Disease ☐ Mitral Valve Prolapse ☐ Rheumatic Fever
☐ Abnormal Heart Rhythm ☐ Heart Attack (when): _____ ☐ Hyperlipidemia ☐ Atrial Fibrillation
☐ Angina/Chest Pain ☐ Peripheral Vascular Disease ☐ Coronary Artery Disease ☐ Palpitations
☐ **No past history**

MUSCULOSKELETAL ☐ Fibromyalgia ☐ Sjogren's ☐ Scleroderma ☐ Gout ☐ Lupus
☐ Osteoarthritis/Osteoporosis ☐ TMJ ☐ Muscle Weakness ☐ Raynaud's ☐ Rheum. Arthritis
☐ **No past history**

LIVER ☐ Hemochromatosis ☐ Cirrhosis ☐ Fatty Liver ☐ HIV ☐ Jaundice
☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ **No past history**

GASTROINTESTINAL ☐ Peptic Ulcer ☐ Pancreatitis ☐ Ulcerative Colitis ☐ Reflux
☐ Angiodysplasia of GI Tract ☐ Diverticulitis/Diverticulosis ☐ Crohn's Disease ☐ IBS (Irritable Bowel)
☐ Barrett's Esophagus ☐ Esophagitis ☐ Celiac Disease
☐ **No past history**

CANCER ☐ Leukemia ☐ Colon ☐ Esophageal ☐ Stomach ☐ Thyroid ☐ Prostate
☐ Chemotherapy ☐ Liver ☐ Tongue ☐ Uterine ☐ Rectal ☐ Ovarian
☐ Radiation ☐ Lung ☐ Cervical ☐ Lymphoma ☐ Brain ☐ **No past history**

RESPIRATORY ☐ COPD ☐ Home Oxygen Use ☐ Pneumonia ☐ Sleep Apnea
☐ Shortness of Breath (on exertion) ☐ Asthma ☐ Bronchitis ☐ CPAP Machine
☐ Shortness of Breath (normal activity) ☐ Emphysema ☐ Tuberculosis (TB) ☐ URI (Upper Respiratory Infection)
☐ Shortness of Breath (at rest) ☐ Coughing/Wheezing ☐ **No past history**

Please list any other significant past medical history:

OTHER _____

SURGICAL HISTORY

*Please indicate if **YOU** have had any of the following surgeries:*

CARDIOVASCULAR
- ☐ Angioplasty
- ☐ Abd. Aneurysm Repair
- ☐ Cardioversion
- ☐ Heart Valve Replacement
- ☐ Coronary Bypass
- ☐ Fem-Pop Bypass (leg arteries)
- ☐ Pacemaker/ICD
- ☐ Cardiac Catherization
- ☐ Stents (when): _____
- ☐ Other: _____

☐ **No past surgeries**

ORGAN TRANSPLANT ☐ Heart ☐ Kidney ☐ Liver ☐ Lung ☐ Other: _____

☐ **No past surgeries**

GENITOURINARY ☐ Bladder ☐ Prostatectomy ☐ Kidney Removal ☐ TURP
☐ Cystectomy w/ Ileal Conduit ☐ Other: _____

☐ **No past surgeries**

GYNECOLOGICAL ☐ Mastectomy (both) ☐ Ovary Removal ☐ C-Section ☐ Fallopian Tube Removal
☐ Mastectomy (left) ☐ Mastectomy (right) ☐ Other: _____
☐ Hysterectomy (abdominal)

☐ **No past surgeries**

GASTROINTESTINAL
- ☐ Appendectomy
- ☐ Cholecystectomy
- ☐ Colonoscopy
- ☐ Gastric Sleeve or Bypass
- ☐ Hernia Repair
- *Type of Hernia* _____
- ☐ Stomach Resection
- ☐ Large Bowel Resection
- ☐ Small Bowel Resection
- ☐ Splenectomy
- ☐ Intestinal Adhesions
- ☐ Colostomy
- ☐ Pancreatic
- ☐ Lap Band
- ☐ Other: _____

☐ **No past surgeries**

Please list all other surgeries you have had in the past:

OTHER _____

CURRENT SYMPTOMS

*Please indicate if you are **CURRENTLY** experiencing any of the following symptoms:*

GENERAL ☐ Fatigue ☐ Fever ☐ Weight Gain (last 3mo.) (amount): _____ ☐ Weight Loss (last 3mo.) (amount): _____ ☐ Night Sweats ☐ Under Stress ☐ Loss of Appetite/Anorexia ☐ Other: _____

☐ **No current symptoms**

SKIN ☐ Basal Cell ☐ Squamous Cell ☐ Melanoma ☐ Skin Rash ☐ Other: _____

☐ **No current symptoms**

HEENT ☐ Oral Ulcers ☐ Eye Pain ☐ Headaches ☐ Voice Changes ☐ Blurred or Double Vision ☐ Hoarseness ☐ Other: _____

☐ **No current symptoms**

HEMATOLOGY ☐ Enlarged Lymph Nodes ☐ Prolonged bleeding ☐ Other: _____

☐ **No current symptoms**

GENITOURINARY ☐ Blood in Urine ☐ Painful Urination ☐ Other: _____

☐ **No current symptoms**

CARDIOVASCULAR ☐ Chest Pain ☐ Difficulty Breathing ☐ Edema/Swelling ☐ Other: _____ ☐ Palpitations

☐ **No current symptoms**

GASTROINTESTINAL ☐ Vomiting ☐ Stomach Pain ☐ Bloating, Belching or Gas ☐ Bowel Movement Changes ☐ Heartburn or Indigestion ☐ Jaundice ☐ Other: _____

☐ **No current symptoms**

I understand that I am financially responsible for all services. I hereby authorize release of any information concerning my (or my child's) health care, advice and treatment provided, for the purpose of evaluating and administrating claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, to be paid directly to Berks Plastic Surgery and Berks Ambulatory Surgery Center.

X _____ Date: _____

Signature of Patient or Parent/Guardian if Minor

I verify that the medical history information is true and accurate to the best of my knowledge.

X _____ Date: _____

Signature of Patient or Parent/Guardian if Minor

I have reviewed and verified all of the above medical information included in this patient registration form.

_____ Date: _____

Signature of Doctor

BERKS PLASTIC SURGERY

Patient Name: #	**What is your reason for your visit today?**
Date :	

Other than the services we are presently providing for you, what additional treatments would you like to learn about? Please check all that apply

- ❑ Skin care advice
- ❑ Skin care products
- ❑ Uneven skin tone
- ❑ Skin discoloration
- ❑ Blotchy skin
- ❑ Rough skin texture
- ❑ Facial redness
- ❑ Brown spots or freckles
- ❑ Age spots
- ❑ Acne
- ❑ Rashes
- ❑ Warts
- ❑ Worrisome moles
- ❑ History of skin cancer
- ❑ Full body skin exam

- ❑ Chemical peel
- ❑ Botox
- ❑ Juvederm
- ❑ Longer, thicker darker lashes
- ❑ Facial fine lines/wrinkles
- ❑ Tired looking skin
- ❑ Thin lips
- ❑ Frown lines between brows
- ❑ Lines around nose & mouth
- ❑ Veins
  - ❑ Legs
  - ❑ Face
- ❑ Drooping brow
- ❑ Tired/aged eyelids
- ❑ Nose size or shape

- ❑ Sagging skin
  - ❑ Face
  - ❑ Body
- ❑ Breast size
  - ❑ Too small
  - ❑ Too big
  - ❑ Too droopy
- ❑ Abdominal area
  - ❑ Fullness
  - ❑ Loose skin
- ❑ Vaginal Rejuvenation
  - ❑ Dryness
  - ❑ Urine Leakage
  - ❑ Looseness
- ❑ Hips
- ❑ Legs (saddle bags)
- ❑ Body Contouring
- ❑ Other

How did you hear about us?

❑ My physician/CRNP/PA-C	*Full name:*
❑ Long time patient	*Name:*
❑ A friend or family member	*Name:*
❑ Billboard	
❑ General internet search	
❑ The Practice website	
❑ Magazine ad	*Date/location:*
❑ Other advertisement	*Specify Ad:*
❑ Other	

❑ Approval to contact you regarding new products, services and special offers	*Best phone number to reach you:*
	Email address:

❑ *I'm not interested in any additional services provided at this time*

↓ For Staff Use Only ↓

Physician / provider : BKR SCL AJH Maria Donna

Follow-up	*Date*	*Completed by (name)*
❑ Initial Inquiry/Information Given		
❑ Contact in future – give date		
❑ Products		
❑ Free consultation		
❑ Procedure scheduled		
❑ Procedure completed		

Comments

BERKS PLASTIC SURGERY INSTITUTE, P.C.

PATIENT RELATED PARTY COMMUNICATION AUTHORIZATION & NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT AND CONSENT

Brian K. Reedy, M.D. ~ *Scott C. Lindsay, D.O.* ~ *A.J. Himmelsbach, N.P.*

PATIENT NAME *(please print)*: _____

I hereby authorize the following person/people to receive or discuss my medical information pertaining to my treatment at Berks Plastic Surgery including, but not limited to:

Appointment Scheduling
Lab or test results via telephone or fax machine
Medications (ordering, pickup, telephone contact, samples)
Insurance or billing questions/ Payment of my bill
Current or future treatment plan

AUTHORIZED PERSON(S): *(If no one, please write "NONE" and sign)*

_____	_____
Name	Name
_____	_____
Relationship to Patient	Relationship to Patient

By signing below, I acknowledge that I have been provided a copy of the Berks Plastic Surgery Institute, P.C. Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of the Notice, and how I may obtain access to and control of this information.

By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates.

Copies of the Berks Plastic Surgery's Notice of Privacy Practices and Patients' Rights and Responsibilities are available upon request.

ACKNOWLEDGEMENT OF RECIEPT OF NOTICES

I acknowledge that I received the Patient Related Party Communication Authorization and the Notice of Privacy Practices for Berks Plastic Surgery.

X _____ _____

Signature of Patient or Personal Representative Date