

Name: _____ Date: _____ Age: _____

Date of Birth: _____ Social Security No.: _____

Male/Female Marital Status: Single/Married/Divorced/Widowed

Local Address: _____

City: _____ State: _____ Zip: _____

Permanent Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E Mail: _____

Patient's Occupation: _____

Employer: _____

Address: _____ Phone: _____

Spouse's Name (Parents Name if Patient is a Minor): _____

INSURANCE INFORMATION

Please Note Cosmetic Procedures are Not Covered by Insurance Companies

Responsible Party or Spouse _____

Primary Insurance _____

Policy No.: _____

Secondary Insurance _____

Policy No.: _____

Reason for Consultation: _____

Referred by: _____

May We Send a Thank You Note to the Person(s) Who Referred You? Y N

Name: _____ Date: _____

Primary Care Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Cardiologist: _____ Phone: _____

Ophthalmologist: _____ Phone: _____

Dermatologist: _____ Phone: _____

MEDICAL DATA:

| | | | | | |
|--|---------------|-----|--------------------|----|-----|
| Height: _____ | Weight: _____ | | | | |
| Heart Murmur | No | Yes | Glaucoma | No | Yes |
| Seizure Disorder | No | Yes | Dry Eyes | No | Yes |
| Thyroid Disorder | No | Yes | Asthma | No | Yes |
| Bleeding Disorder | No | Yes | Diabetes | No | Yes |
| Cold Sores | No | Yes | Bruisability | No | Yes |
| Abnormal Scars | No | Yes | Stroke | No | Yes |
| High Blood Pressure | No | Yes | Blood Clots | No | Yes |
| Irregular Heartbeat | No | Yes | Phlebitis | No | Yes |
| Immune System Disorder | No | Yes | Arthritis | No | Yes |
| Hepatitis | No | Yes | Blood Transfusions | No | Yes |
| Malignant Hyperthermia and/or Family History | | | | No | Yes |
| Other _____ | | | | | |

Date of Previous Surgeries, Serious Illnesses or Injuries (Including Any Cosmetic Procedures): _____

_____ Any Complications? _____

Number of Pregnancies: _____ Any Complications? _____

Allergies & Sensitivities: _____

Medications and Vitamins you Currently Take: _____

Do You Drink Alcohol? No Yes Frequency: _____

Do You Use Recreational Drugs? No Yes Frequency: _____

Do You Smoke? No Yes Amount: _____

Did You Ever Smoke: _____ Date Stopped: _____

Please Note – Smoking Increases the Risk of Surgery!

VISUAL IMAGES

As a Plastic Surgeon dedicated to improving patient care, Dr. Sarraga emphasizes patient and professional education and understanding. Using "before" and "after" photographs or images is frequently among the best ways to demonstrate the possible benefits or indications for a procedure or technique. Dr. Sarraga kindly asks for your assistance in this process.

VISUAL IMAGE RELEASE FORM

I, _____ hereby grant permission to Dr. Andres Sarraga and his staff to take and use visual images or photographs of me. I consent to any of the photographs being used in any manner or media such as lectures, consultations, articles, texts or web sites.

I release Dr. Andres Sarraga and his employees from any liability or damages arising from such use. Dr. Sarraga and his staff shall retain all rights to said materials.

By signing below, I acknowledge that I have read and understand the above and freely give my consent according to the terms of this **Visual Image Release Form**.

Yes, you **may use** my images (photos) to show other patients and/or on a website

I do not want my images released

Print Name _____ Signature _____

Date _____

(If the patient is a minor, please complete the following):

Patient is a minor, _____ years of age, and I/we, the undersigned, are the Parent(s) or guardian(s) of the patient and do hereby consent for the patient.

Patient: _____

Parent(s) or Guardian(s): _____

Date: _____