

Allegheny Center for Reconstructive Surgery- Patient Information Sheet
This information is Confidential

DATE: _____

Patient Information

Last Name: _____ First Name: _____ MI: _____

Street: _____ City: _____ State: _____ Zip _____

Phone (Home): _____ (Other Phone): _____ Driver's License No./State _____

Birth Date: _____ Sex: Female Male Social Security No. _____

Marital status: single married widowed divorced Legally separated

Employment Information:

Employer: _____

Street: _____ City: _____ State: _____ Zip _____

Status: Full-Time Part-Time Not Employed Retired-Retirement Date _____

Work Phone: _____ Ext. _____ Location (Dept.) _____

Spouse, Parent, or Guardian:

Name of Spouse, Parent, Guardian: _____ Date of Birth: _____

Student Status: Non-Student Full-Time Part-Time

Marital Status: Single Married Widowed Divorced Legally Separated

Spouse Employer _____ Street: _____

City: _____ State: _____ Zip _____

Social Security No. of Spouse or Parent: _____ Phone (Home): _____ (Other): _____

Family Contact: _____ Phone (Home): _____ Other: _____

Contact person in case of an emergency: _____ Relationship: _____

Contact Phone _____ Other Phone _____

Account Information:

Referring Provider: _____ Primary Doctor: _____

Referral Source: Physician Yellow Pages Friend Physician Locators

Hospital (Name of Hospital) _____

PLEASE COMPLETE INFORMATION ON BACK OF SHEET

Insurance Information (Policy #1 – Primary) HMO ___ Yes ___ No

Insurance Co. Name: _____ Phone No. _____

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

Policy Holder: _____ Relationship to Insured: ___ Self ___ Spouse ___ Child ___ Other

Policy Number: _____ Group Number: _____ Policy Holder's Birth Date: _____

Policy Holder's SS #: _____ Policy Holder's Employer: _____

Policy Start Date: _____ Policy End Date: _____

Insurance Information (Policy #2 – Secondary) HMO ___ Yes ___ No

Insurance Co. Name: _____ Phone No. _____

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

Policy Holder: _____ Relationship to Insured: ___ Self ___ Spouse ___ Child ___ Other

Policy Number: _____ Group Number: _____ Policy Holder's Birth Date: _____

Policy Holder's SS #: _____ Policy Holder's Employer: _____

Policy Start Date: _____ Policy End Date: _____

Worker's Comp

Employer Name _____ Contact Person: _____ Phone _____ Ext# _____

Compensation Insurance: _____ Date of Injury: _____

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

Claim Number: _____ Policy Number: _____

Claim Representative: _____ Phone: _____ Fax: _____

Auto Accident

Auto Insurance Carrier: _____ Date of Accident: _____

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

Policy Holder's Name: _____

Policy Number: _____ Claim Number: _____

Claim Representative: _____ Phone: _____ Fax: _____

MEDICAL HISTORY

PATIENT NAME: _____

REASON FOR VISIT TODAY: _____

Height: _____ Weight: _____ Do you or have you ever taken steroids? _____

Do You Have:			Have You Ever Had:		
	Yes	No		Yes	No
Heart Disease:	()	()	Heart Attack:	()	()
Diabetes:	()	()	Stroke:	()	()
Arthritis:	()	()	Rheumatic Fever:	()	()
High Blood Pressure:	()	()	Kidney Disease:	()	()
Thyroid Disease:	()	()	Cancer:	()	()
Epilepsy:	()	()	Phlebitis (Blood Clot):	()	()
Asthma:	()	()	Jaundice:	()	()
Emphysema:	()	()			
Chest Pain:	()	()	Date of Last Menstrual Period:	_____	
Ankle Swelling:	()	()	Date of Last Mammogram:	_____	
Prolonged Bleeding:	()	()	Number of Pregnancies:	_____	

Date of last PAP _____

Do You Have Any Unusual Medical Problems? _____

Do You Smoke? _____ How Many Per Day? _____ How Many Years? _____

Did You Ever Smoke? _____ How Many Per Day? _____ When Did You Stop? _____

How Many Years Did You Smoke? _____

Allergies To Medications

Medication:	Reaction:
1.	
2.	
3.	

Current Medications

Medication:	Dosage:	How Often:
1.		
2.		
3.		
4.		
5.		
6.		

Past Surgeries

Type of Surgery	Date
1.	
2.	
3.	
4.	
5.	

Patient's Signature: _____

Date: _____