**Robert Najera, M.D. Cosmetic and Plastic Surgery**

**PATIENT INFORMATION SHEET**

Name: First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone# (\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Work# (\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Cell# (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Emergency# (\_\_\_) \_\_\_\_-\_\_\_\_\_ Emergency Contact Name \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_

Social Security Number \_\_\_\_ -\_\_\_\_\_-\_\_\_\_\_ Date of Birth\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_ Male Female

E-mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ @\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_ Marital Status S M D W

Who is your primary care physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: (\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_

(If you go to a group please specify the name of the physician you see most often.)

Pharmacy Name, Address & Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Status: Employed Student Retired

Employer Name, Address, & Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

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**INSURANCE INFORMATION**

Name of Primary Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_

Name of Secondary Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_

**POLICY HOLDER INFORMATION (If Other Than Patient)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Address: (if different from patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOW DID YOU HEAR ABOUT OUR PRACTICE?**

\_\_\_A Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Family Member/Friend Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Newspaper/Television Which publication/program \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Seminar Date & Topic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Internet Website: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Other Please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization to Release Information:** I authorize Robert Najera, M.D. to release any information necessary, acquired in the course of my treatment, to process insurance claims. **Initial Here \_\_\_\_\_\_\_**

**Authorization to Pay Benefits Directly:** I authorize my insurance company to pay Robert Najera, M.D. directly for medical service rendered. I understand that I will be responsible for non-covered charges, balances after company benefits, deductibles and copayments. **Initial Here \_\_\_\_\_\_\_**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_**

**Robert Najera, M.D.**

**Cosmetic and Plastic Surgery**

**Release of Information Authorization**

Please mark below for release of information concerning your healthcare and/or financial arrangements:

Release information ONLY to me: \_\_\_ Yes \_\_\_\_ No

Release of Information to Spouse: \_\_\_ Yes \_\_\_\_ No

Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Release of Information to Other Individual: \_\_\_ Yes \_\_\_\_ No

Name & Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferences**

I prefer to be contacted in the following manner:

Phone#: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Leave message with detailed information.

Leave message with contact number only.

Do not leave message.

I am fully aware my health information will be transmitted by electronic transmission, fax transmittal, internet or e-mail.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient/Guardian Date

**Consent to receive text messages about appointment reminders:**

**Patients in our practice**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number to receive appointment reminders. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing.

* The **CELL PHONE NUMBER** that I authorize to receive
  + TEXT Reminders
    - Is: (\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details)

**Robert Najera, M.D.**

**Cosmetic and Plastic Surgery**

**Patient Medical History**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe briefly your reason for coming to my office: (date of injury, if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you currently under the care of or have you ever been treated by a Medical Physician for any significant illness other than colds, flu or virus? If so, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following conditions: If YES, please explain:

Cardiac History No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding Problems No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hypertension No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIV/AIDS No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any significant illnesses or cancer that runs in your family? Please provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you had any surgical procedures in the past?

Date (mm/yy) Type of Surgery Name of Doctor Hospital

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Number of children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ vaginal delivery/C-Section

When was your last mammogram? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last EKG? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

Alcohol Use: Never \_\_\_\_\_\_\_\_ Occasional \_\_\_\_\_\_\_\_\_ Drinks per week \_\_\_\_\_\_\_\_\_\_\_\_

Do you Smoke Cigarettes: Yes No If yes, how many per day? \_\_\_\_\_

Do you use smokeless tobacco Yes No

**CURRENT MEDICATIONS**

**(Include herbs, vitamins & any other over-the-counter medications.)**

Aspirin Yes No

Oral Contraceptives Yes No

Blood Thinners Yes No

Name of Medication Dosage Frequency Purpose

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies to Medications?

Penicillin Yes No if YES, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Local Anesthesia Yes No if YES, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

General Anesthesia Yes No if YES, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any others Yes No if YES, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies such as creams, tape, latex etc.? Yes No

Do you have any bleeding tendencies? Yes No

**Symptoms Review:** Please circle any symptoms you’ve had in the past few months:

**General Symptoms Hematologic/Allergy Gastrointestinal Cardiovascular**

Fever/Chills Clotting Problems Abdominal pain Chest pain

Change in appetite Swollen Glands Diarrhea Chest palpitations

Headache Hay fever Blood in stools Shortness of breath

Wt. loss/gain>10 lbs. Prolonged bleeding Bloating Swelling of legs

Nausea /vomiting Easy bruising Constipation Palpitations

**Neurological** **Endocrine Musculoskeletal ENT**

Memory loss Excessive thirst Joint pain Cold

Dizzy spells Intolerance to hot/cold Back pain Sore throat

Numbness Excessive fatigue Weakness Hearing loss

Insomnia History of Glaucoma

Tremors

Loss of balance

**Skin Respiratory Gynecologic Psychiatric**

Skin Rash Wheezing Breast pain or lump Depressive symptoms

Boils Frequent cough Hot flashes Thoughts of suicide

Change in - Cough up blood Vaginal Bleeding Anxiety

Appearance of mole Trouble breathing vaginal discharge High Stress level