COASTAL

PLASTIC SURGERY

MEDICAL INFORMATION

To ensure optimal care, please answer the following thoroughly, filling in all the blank fields.

PERSONAL DETAILS

Name of Patient: ____________________

Date: ____________________

Reason for Consultation: ____________________

Age: ________ Height: ________ Weight: ________ Date of Last Physical Exam: ____________

MEDICAL QUESTIONNAIRE

List Any Medication Allergies & reactions: ____________________

____

Are you allergic to any topical preparations? Tape _______ Betadine _______ Latex _______

Others: ____________________

Are you currently under medical treatment? ☐ YES ☐ NO

Past/Present Health Conditions (ex. High Blood Pressure, Diabetes): ____________________

____

Previous Surgeries (Date/Procedures/Physician): ____________________

____

____

MEDICAL QUESTIONNAIRE

Major Illnesses or Hospitalizations/Date: ______________________________

____

____

Please list all medications (prescriptions/non-prescription/herbal), you are currently taking or take on a routine basis: ______________________________

____

____

Do you take any of the following?

Blood Thinners Including Aspirin ☐ YES ☐ NO

Vitamin E ☐ YES ☐ NO

Ibuprofen Motrin/Advil ☐ YES ☐ NO

Herbal Tea Including Green Tea ☐ YES ☐ NO

Herbal Supplements ☐ YES ☐ NO

Preworkout or Fat Burners ☐ YES ☐ NO

Nicotine Use (ex. cigarettes, cigars, vaping, hookah etc.) This includes socially: ☐ YES ☐ NO ☐ QUIT

If answered YES, How many packs a day? ______________________________

If answered QUIT, What is the quit date? ______________________________

Alcohol Use: ☐ DENIES ☐ SOCIALLY ☐ DAILY

Use of illegal substances? ☐ YES ☐ NO

If answered YES, what and when was the last time? ______________________________

Family Physician/PCP: ______________________________

Phone: ______________

Pharmacy Name: ______________________________

Pharmacy Address: ______________________________

Phone: ______________

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PATIENT REGISTRATION FORM

Name of Patient:

Last: ______________________ First: ______________________ Middle Initial: _____

Address: (Street) ________________________________ (City) ___________________

(State) __________ (Zip) ____________

Home Phone: ______________ Cell Phone: ______________

Work Phone: ______________

*I authorize Dr. Adam's office staff to leave messages/texts for me on: ☐ HOME ☐ CELL ☐ WORK

Employer: ____

Address: ____

Date of Birth: ______________ Sex: ______________ Marital Status: ______________

Spouse Name: ____________________________

May we email you any paperwork, consents or instructions related to your visit and/or procedure? ☐ YES ☐ NO

May we email you specials / promotional offers? ☐ YES ☐ NO

May we email you newsletters? ☐ YES ☐ NO

Email Address: ____

Emergency Contact: ________________________

Phone: _________________

Relation to Emergency Contact: _______________________

PATIENT REGISTRATION FORM

How did you hear about us? ____

____

Name of Referring Physician or patient? ____________________________________

FINANCIAL POLICY

Coastal Plastic Surgery does not accept insurance, workers' compensation or third-party billing.

Payment for services is due, in full, per the terms on our financial quotes.

Your signature below confirms that you understand Coastal Plastic Surgery does not accept insurance, workers' compensation or third-party billing, and you agree to abide by our financial policy.

Patient's Signature: ____

Date: ______________________

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SOCIAL MEDIA CONSENT

Consenting to connect with Coastal Plastic Surgery on social media is not a requirement of being a patient of Coastal Plastic Surgery. You are under no obligation to consent, and if you do consent, you may revoke the consent at any time. However, we love the opportunity to connect with our patients and keep in touch! If you would like to connect with us, please let us know!

Do you consent to connecting with us on social media? ☐ YES ☐ NO

If yes, please provide your social handles below (for all apps that apply):

Facebook: ______________________________

Instagram: ______________________________

Tik Tok: ______________________________

May we repost your social media photos? ☐ YES ☐ NO ☐ Maybe, please message me first!

Please note: the posting of your Coastal Plastic Surgery owned before/after photos is a separate consent that is included in your pre-op packet. We respect our patients' decisions regarding this consent. Thank you for being part of our Coastal Plastic Surgery family!

Patient Name (Printed): ____

Patient Signature: ______________________________ Date: ____________________