*Board Certified, American Board of Plastic Surgeons*
**DAVID A. NEWMAN, M.D. F.A.C.S.**
Breast and Cosmetic Surgery Center

*Plastic and Reconstructive Surgery*

Hancock Medical Center • 25150 Hancock Ave. #110 • Murrieta, California 92562 • (951) 698-3344 • (951) 698-0775

## PATIENT REGISTRATION

**PATIENT** (include middle initial)

Name: _____ Social Security Number: _____

Address: _____ E-MAIL ADDRESS: _____

City: _____ State: ____ Zip:_____ Employer: _____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

PATIENT: D.Lic.#: _____ Birthdate: _____ Age:____ Sex:_____ Married ____ Single ____

Additional contact in case of emergency: Name: _____/Relationship:_____ Phone: _____

Referring Physician/Patient or Friend: _____

Primary Physician: _____

Request: ❑ Cosmetic Consultation ❑ Other: _____

## INSURANCE

**Please give receptionist insurance card to copy**

Name of Insurance Company: _____ ❑ PPO ❑ HMO

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the release of any medical information or photographs necessary for my surgery and to process my insurance claim or procedure in compliance with HIPAA regulations.

**Signature:** _____ **Date:** _____

## AUTHORIZATION FOR PAYMENT

I authorize payment of medical benefits to Dr. Newman and am fully responsible for all charges incurred.

**Signature:** _____ **Date:** _____

## CONSENT FOR PHOTOGRAPH

(not for internet)

**Signature:** _____ **Date:** _____

## MEDICAL HISTORY

Do you take blood thinners? ❑ No ❑ Yes _____

Alcohol: ❑ Never Drink(s) per day: _____ Drink(s) per week: _____

Any street drug use? _____

Do you take steroids? _____

Do you have, or have you had, any risk factors for HIV/AIDS? _____

Do you take any diet aids? ❑ No ❑ Yes _____

**LIST ALL MEDICATIONS:** (including vitamins, supplements (energy bars, protein shakes), diet products, birth control, hormones)

| Name | Dose | How Often |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Tobacco: Never ❑ Number of packs per day:_____ Number of years: _____ Date last used: _____Nicorotte gum / patch : _____ vape: _____ marijuana:_____ pipes: _____**

What medications are you **allergic** to and what is the reaction? _____

Any **allergies** to Penicillin, sulfa, iodine or latex_____

Does it take **longer** than five minutes to stop bleeding once cut (shaving, etc.)? _____

Women: Could you be pregnant? ❑ No ❑ Yes _____

❑ Ever been told you have an **elevated** Blood Pressure reading _____

### Please list all surgeries in the past (any problems with surgery or anesthesia?):

1. _____
2. _____
3. _____
4. _____

Please check or circle and explain any of the following conditions which you now have or have had in the past:

❑ Anemia _____
❑ Stroke_____
❑ Heart Attack / Chest Pain _____
❑ Heart Problems _____
❑ Mitral Valve Prolapse (any symptoms now?) _____
❑ History of Blood Clots in Legs or Pulmonary Embolism _____
❑ Thyroid Disorders _____
❑ Emphysema _____
❑ Shortness of Breath _____
❑ Asthma_____
❑ Dry Eyes _____
❑ Glaucoma _____
❑ Cataracts _____
❑ Tuberculosis_____
❑ Hepatitis / Jaundice / Liver disease _____
❑ Palpatations _____
❑ Acid Reflux, Indigestion, Heartburn _____
❑ Chronic fatigue or fibromyalgia_____

❑ Obesity (gastric bypass surgery?)_____
❑ Kidney Problems _____
❑ Cancer _____
❑ Arthritis / Joint Pain _____
❑ Back Pain _____
❑ Ulcers _____
❑ Depression / Anxiety _____
❑ Fainting / Dizziness _____
❑ Headaches _____
❑ Seizures / Epilepsy _____
❑ Infections _____
❑ Stomach Problems _____
❑ Chronic Fatigue Syndrome _____
❑ Skin Diseases_____
❑ Bleeding Problems _____
❑ Hysterectomy_____
❑ Diabetes _____
❑ Family history of blood clots, heart attack, DVT or stroke?_____
❑ Sleep Apnea Syndrome _____

The above information is true and correct.

**Signature:** _____ **Date:** _____