



Gregory O. Dick, MD, FACS
Plastic, Reconstructive & Cosmetic Surgery

PLEASE PRINT

PATIENT NAME _____ BIRTH DATE _____ SEX ☐ M ☐ F

LAST NAME FIRST NAME MIDDLE

PATIENT'S ADDRESS _____ STREET CITY STATE ZIP CODE

HOME PHONE _____ CELL PHONE _____

PATIENT'S SS# _____ AGE _____ MARITAL STATUS: ☐ S ☐ M ☐ W ☐ D

E-MAIL _____

PATIENT EMPLOYER _____

EMPLOYER ADDRESS _____ EMPLOYER PHONE NO. _____

SPOUSE _____ BIRTHDATE _____ PHONE _____

SPOUSE'S EMPLOYER _____

EMERGENCY CONTACT

NAME _____

RELATIONSHIP TO PATIENT _____ PHONE _____

REFERRING PHYSICIAN _____ PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ POLICY NO. _____ GROUP _____

POLICY HOLDER'S NAME _____ BIRTHDATE _____

SOCIAL SECURITY NUMBER _____ RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE _____ POLICY NO. _____ GROUP _____

POLICY HOLDER'S NAME _____ BIRTHDATE _____

I VERIFY THAT ALL INFORMATION ON THIS FORM IS CORRECT.

DATE X _____
PATIENT

AUTHORIZATION TO RELEASE MEDICAL INFORMATION, PATIENT RESPONSIBILITY AND CLAIM PAYMENT AUTHORIZATION

I AUTHORIZE GREGORY O. DICK, MD, FACS AND STAFF TO SUBMIT MEDICAL CLAIMS TO MY HEALTH INSURANCE CARRIER. I UNDERSTAND THAT I WILL BE LIABLE FOR ALL PHYSICIAN CHARGES, INCLUDING BUT NOT LIMITED TO, DEDUCTIBLES, CO-PAYS AND/OR CO-INSURANCE. I UNDERSTAND THAT ALL COLLECTION AND/OR ATTORNEY FEES ON PAST DUE ACCOUNTS WILL ULTIMATELY BE MY RESPONSIBILITY. I AUTHORIZE DIRECT PAYMENT FROM MY INSURANCE CARRIER FOR ALL SERVICES RENDERED BY GREGORY O. DICK, MD, FACS BE MADE DIRECTLY TO HIM.

DATE X _____
PATIENT

(OVER) ➡

MEDICAL INFORMATION

PRIMARY PHYSICIAN'S NAME _____

ADDRESS _____

PHONE NUMBER _____

REASON FOR SEEING DR. DICK TODAY _____

PAST MEDICAL HISTORY

HAVE YOUR EVER HAD SURGERY? _____ YES _____ NO

TYPE

YEAR

_____	_____
_____	_____
_____	_____

DO YOU HAVE	YES	NO
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
TB	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>

ARE YOU ALLERGIC TO		
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Novocaine	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>

OTHER DRUG ALLERGIES, PLEASE LIST

LIST ALL MEDICATIONS YOU TAKE, INCLUDING SUPPLEMENTS

PLEASE LIST ANY ADDITIONAL MEDICAL PROBLEMS

DO YOU HAVE	YES	NO
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Nervous Condition (Anxiety)	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU EVER HAD		
Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>

DO YOU TAKE		
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Blood thinner medication	<input type="checkbox"/>	<input type="checkbox"/>
Diuretics (water pills)	<input type="checkbox"/>	<input type="checkbox"/>
Heart medication	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure med.	<input type="checkbox"/>	<input type="checkbox"/>
Steroids	<input type="checkbox"/>	<input type="checkbox"/>

DO YOU DRINK ALCOHOL?		
DO YOU SMOKE?	<input type="checkbox"/>	<input type="checkbox"/>
Have you smoked in the past?	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY HISTORY		
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU, OR HAVE YOU EVER, HAD A PROBLEM WITH

ALCOHOL ☐ DRUGS ☐ NOW ☐ PAST ☐

THANK YOU!