Thank you for scheduling a consultation with our office. We are looking forward to meeting you and exceeding your expectations! Enclosed you will find patient information paperwork. We recommend that you fill these out at home and send them back in the enclosed stamped envelope. It is important for us to know your health history as thoroughly as possible, even if it doesn’t seem relevant to what you’re coming in to discuss. Keep in mind that when it comes to the human body, everything is connected! When discussing surgery, we’d rather have too much information than not enough.

**What to expect the day of your consultation:**

Plan to spend 1 to 2 hours at the office the day of your first appointment.

**First**, you will meet one of our amazing nurses: Ashley, Julie, Dawn, Sarah, or Jan. They will review your paperwork with you and ask some more questions in regards to your health and your procedure of interest. You will have the opportunity to register with our TouchMD system so that you can have access to some of the information about your consultation on your computer at home, if you choose.

**Next**, you will meet the surgeon. The doctor will discuss the procedure and give you some expert advice on how to best achieve the results for you. Photos will be taken, if appropriate, so that the doctor has a baseline to reference back to throughout your entire surgical experience. These photos are confidential and stored within our internal server as part of your medical record.

**Again**, a nurse will spend some time with you discussing the details of surgery and offering you as much education about the procedure as you’d like. This is a great time to make sure that you have all your questions answered and feel completely comfortable with all the information you’ve been given.

**What to bring with you:**

- Your completed paperwork.
- Your insurance information, including cards and ID.
- Questions! We recommend making a list at home so that in the excitement of your visit nothing gets forgotten.
- A friend or family member. The support is nice, an extra set of ears listening never hurts and we love to meet new people!
- A smile and sometimes... a little patience. We work **VERY** hard to stay on schedule but also strive to give each patient the time that they need, rather than hurrying them in and out, which can sometimes throw a wrinkle in expected times. Please understand that we will give you the same respect when it’s your time.
If you need to reschedule your appointment, please let us know at least one day in advance. If you have any questions at all about your visit, our front office staff: Erin, Machelle, and Laura are available or feel free to talk to our Patient Coordinator, Jan. We want you to feel completely prepared and comfortable!

We look forward to seeing you.

Sincerely,

The Staff at Partners in Plastic Surgery

616-464-4420
WELCOME!

Patient Information:  □ Mr.  □ Mrs.  □ Ms.  □ Miss  □ Dr.  □ Date: __________

Patient Name: ____________________________________________________________

Address: ________________________________________________________________

City: __________________________  State: __________  Zip Code: _________________

Phone (Home): _________________  (Work) _________________  (Cell) _______________

Email address: __________________________

SSN: __________________________  Birthdate: __________________________  Gender:  □ Male  □ Female

Patient’s Marital Status:  □ Single  □ Married  □ Widowed  □ Divorced

Would you like to be added to our email newsletter list for ongoing information and specials?  □ Yes  □ No

Patient’s Employer: __________________________  Occupation: __________________

Employer Address: __________________________  Phone #: ___________________

Ethnic Background:  □ American Indian/Alaska Native  □ Asian  □ Black/African American
    □ Native Hawaiian/Pacific Islander  □ White  □ Other Race  □ Decline to answer

Preferred Language: __________________________

Reason for Visit: ____________________________________________________________________________________________

Other Information

In Case of Emergency, who should we notify: _________________________________________________________________

Emergency Contact’s relationship to patient: __________________________  Phone #: __________________________

How did you hear about us?

☐ Physician: __________________________  ☐ Hospital: __________________________

☐ Another Patient: __________________________  ☐ Friend: __________________________

☐ Website: __________________________  ☐ Telephone Directory: __________________________

☐ T.V. Ad  ☐ Seminar

☐ Publication: __________________________

☐ Other (i.e., Employee, Attorney, Referral Line): ______________________________________________________________

Patient’s Signature: __________________________  Date: __________
Patient Name: ___________________  Today’s Date: ____________
Date of Birth: ________________

**Insurance Information**

*PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST FOR COPYING.*

**Primary** Insurance Company: __________________________
Subscriber’s Name: ___________________  Relation to Patient: ______________
Subscriber’s Address: __________________________
Subscriber’s Birthdate: ________________  Subscriber’s SSN: __________________
Subscriber’s Employer: ___________________  Subscriber’s Phone: ______________

**Secondary** Insurance Company: __________________________
Subscriber’s Name: ___________________  Relation to Patient: ______________
Subscriber’s Address: __________________________
Subscriber’s Birthdate: ________________  Subscriber’s SSN: __________________
Subscriber’s Employer: ___________________  Subscriber’s Phone: ______________

Is this a work-related injury? ☐Yes ☐No  Is this an auto-related injury? ☐Yes ☐No
If yes to either of the above, where did injury occur? ____________________________
If yes to either of the above, on what date did injury occur? ____________________________

**Physician Information**

Please provide information about the physician(s) who provide care to you:

Primary Care or Family Physician: ___________________________  Phone: ______________
Referring Physician: ___________________________  Phone: ______________

I have authorized my doctor to correspond with the physician(s) listed above concerning my condition and any treatment plan that may be developed. ☐Yes ☐No
If no, please list the reason(s) you do not wish your doctor to correspond with your other physicians: ____________________________

Patient’s Signature: ___________________________  Date ______________
Consents

1) **Consent for general treatment.** I request and authorize healthcare services to be provided by Partners in Plastic Surgery and members of its clinical staff.

2) **No representation for guarantees.** I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no oral or written representations or guarantees have been made to me as to the results of any diagnosis, treatment, and medical care that I (or the patient, if a minor) may receive as a patient at Partners in Plastic Surgery.

3) **Teaching facility.** I am aware that Partners in Plastic Surgery operates or assists in teaching programs in a number of health care professions and participates in approved medical research. I consent to the observation of my diagnosis and treatment and the review of my records for purposes of providing an essential part of these programs. I understand that this will be done with the utmost respect for my confidentiality and any identifying information shall not be published without my consent.

4) **Release of information.** I hereby authorize Partners in Plastic Surgery, its agents, and employees to release copies of my medical records, including information from prior treating physicians, x-rays, reports, and information about substance abuse treatment, mental illness, HIV infection, Acquired Immunodeficiency Syndrome, venereal disease or tuberculosis.
   a. to any governmental agency, medical service organization, insurance company, auditing agency engaged by Partners in Plastic Surgery or a third party payer, employer or physician for the purpose of processing any claims for benefits.
   b. to any physician or health care facility to which I, the patient, may be referred to for the purpose of continued patient care.
   c. to the physician/facility who has referred me to Partners in Plastic Surgery.

5) **HIV testing.** You are hereby notified pursuant to Michigan Law, that you may be tested for the presence of HIV, HIV antibody, Hepatitis B and Hepatitis C with or without your consent if any professional or other health facility employee sustains a needle stick, mucous membrane, or open wound exposure to your blood or other body fluids. This test is permitted by Michigan Law and is for your protection as well as the protection of the healthcare professionals at Partners in Plastic Surgery.

6) **Insurance coverage.** I hereby authorize Partners in Plastic Surgery to file and pursue a claim for payment of my charges with my insurance carrier as specified now or requested later. I authorize release of information to all my insurance companies. I understand that I am financially responsible for any balance not covered by my insurance. I also understand that Partners in Plastic Surgery may or may not participate with my current insurance carrier.

THIS RELEASE IS SUBJECT TO WRITTEN REVOCATION AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. THE UNDERSIGNED RELEASES PARTNERS IN PLASTIC SURGERY FROM ALL LEGAL RESPONSIBILITY OF LIABILITY THAT MAY ARISE FROM THIS AUTHORIZATION.

I hereby certify that I have read this form or it was read to me and that I fully understand the contents of this form.

Patient Signature: ___________________________________________________________ Date: ___________
Patient Name: ____________________________  Today's Date: __________________
Date of Birth: ____________________________ Height: __________________
Age: ________________  Weight: ________________

To your knowledge, do you **now** or have you ever **had** any of the following?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Intertrigo (rashes/skin irritation)</td>
</tr>
<tr>
<td>Anemia</td>
<td>Irregular Heart Beats</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Kidney Stones</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Liver Disease</td>
</tr>
<tr>
<td>Asthma</td>
<td>Loose or Missing Teeth</td>
</tr>
<tr>
<td>Auto-Immune Disease</td>
<td>Lupus</td>
</tr>
<tr>
<td>Bleeding Disorders</td>
<td>Lyme Disease</td>
</tr>
<tr>
<td>Blood Clots</td>
<td>Mitral Valve Prolapse</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>Multiple Sclerosis</td>
</tr>
<tr>
<td>Bone Fractures</td>
<td>Obesity</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>Pacemaker</td>
</tr>
<tr>
<td>Bruise/Bleed Easily</td>
<td>Phlebitis</td>
</tr>
<tr>
<td>Cancer</td>
<td>Polio/Meningitis</td>
</tr>
<tr>
<td>Caps/Dentures/Bridges</td>
<td>Post-traumatic Stress Disorder</td>
</tr>
<tr>
<td>Chest Pain / tightness</td>
<td>Psoriasis</td>
</tr>
<tr>
<td>Connective Tissue Disease</td>
<td>Pulmonary Embolism</td>
</tr>
<tr>
<td>COPD</td>
<td>Rheumatic Fever</td>
</tr>
<tr>
<td>Crohn’s Disease/Colitis</td>
<td>Rheumatoid arthritis</td>
</tr>
<tr>
<td>Depression</td>
<td>Scoliosis</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Seizures</td>
</tr>
<tr>
<td>Eczema</td>
<td>Shortness of Breath</td>
</tr>
<tr>
<td>Emphysema</td>
<td>Skin Cancer</td>
</tr>
<tr>
<td>Facial Fractures</td>
<td>Skin Disease</td>
</tr>
<tr>
<td>Fainting Spells</td>
<td>Sleep Apnea</td>
</tr>
<tr>
<td>Frequent Nose Bleeds</td>
<td>Stroke</td>
</tr>
<tr>
<td>Head Injury</td>
<td>Thyroid Problems</td>
</tr>
<tr>
<td>Headaches/Migraines</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>Ulcers</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>Urinary Tract Infection</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>Weight Loss</td>
</tr>
<tr>
<td>Heart Murmur</td>
<td>Xray Therapy</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>OTHER problems (not listed)</td>
</tr>
<tr>
<td>Herpes</td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
</tr>
<tr>
<td>High Cholesterol</td>
<td></td>
</tr>
<tr>
<td>HIV Positive</td>
<td></td>
</tr>
<tr>
<td>Hives</td>
<td></td>
</tr>
</tbody>
</table>

Reviewed by (nurse initials) / Date ________________
Patient Name: ____________________________

Date of Birth: __________________________

Today’s Date: __________________________

**Medications**

Please list all medications (prescription and non-prescription) you are presently taking (include dosage and frequency) Be sure to include vitamins and herbal supplements, i.e. Fish Oil, Garlic, Ginkgo, Chamomile, St. John’s Wort, etc.

☐ If none, please check.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

List any medication allergies:

☐ If none, please check.

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

Do you have allergies to **Latex**?  ☐ Yes  ☐ No  
Do you have allergies to **Adhesives**?  ☐ Yes  ☐ No

**Please list all surgeries and major hospitalizations:**

☐ If none, please check.

<table>
<thead>
<tr>
<th>Description of procedure</th>
<th>Date of procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Reviewed by (nurse initials) / Date __________________________
Patient Name: ____________________

Today’s Date: _______________

Date of Birth: ________________

---

**Family Medical History**

Have any family members suffered from any of the conditions listed below?

☐ Adopted – family history unknown.

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Relation to you</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Breast Cancer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cancer (please specify what type)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diabetes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Heart Disease/ Stroke/ Heart Attack</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High Blood Pressure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lung Disease/ Asthma/ Emphysema</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Malignant Hyperthermia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rheumatoid Arthritis/ Lupus/ Fibromyalgia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OTHER</td>
</tr>
</tbody>
</table>

---

**Social History**

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes ☐ No If yes, how many? _____________ Their ages? ________________

Occupation: __________________________________________

Do you consume alcohol? ☐ Yes ☐ No If yes, how many days per week? __________________________

Do you smoke cigarettes or use tobacco products? ☐ Yes ☐ No

If yes, how many cigarettes per day? ________________

If no, have you ever smoked or used tobacco products? ☐ Yes ☐ No

---

Patient’s Signature_____________________________________________ Date __________________

Physician’s Signature___________________________________________ Date __________________

Reviewed by (nurse initials) / Date ___________________________
DIRECTIONS TO OUR OFFICE

We are located in the East/South corner of East Paris and Lake Drive. We are the first drive on the right past the intersection and the large white address numbers are located at the top of our red brick building located behind Lake Michigan Credit Union. Our office is on the second floor.

Directions from the NORTH (Big Rapids)

- Take 131 SOUTH towards GRAND RAPIDS.
- Take either 96 EAST (around town) or 196 EAST (through town) towards LANSING.
- Take the CASCADE WEST exit (exit #40A).
- Turn LEFT at next light onto EAST PARIS.
- Turn LEFT at 2nd light onto LAKE DRIVE.
- Take FIRST DRIVE on the RIGHT.
- We are in the building behind Lake Michigan Credit Union.

Directions from the EAST (Lansing)

- Take 96 WEST towards GRAND RAPIDS.
- Take the CASCADE WEST exit (exit #40A).
- Turn LEFT at 2nd light onto EAST PARIS.
- Turn LEFT at 2nd light onto LAKE DRIVE.
- Take FIRST DRIVE on the RIGHT.
- We are in the building behind Michigan Commerce Bank.

Directions from the SOUTH (Kalamazoo)

- Take 131 NORTH to GRAND RAPIDS.
- Take 196 EAST (through town) towards LANSING.
- Take the CASCADE WEST exit (exit #40A).
- Turn LEFT at next light onto EAST PARIS.
- Turn LEFT at 2nd light onto LAKE DRIVE.
- Take FIRST DRIVE on the RIGHT.
- We are in the building behind Lake Michigan Credit Union.
Directions from the WEST (the shore of Lake Michigan)

- Take either 196 EAST (through town) or 96 EAST (around town) towards LANSING
- Take the CASCADE WEST exit (exit #40A)
- Turn LEFT at next light onto EAST PARIS.
- Turn LEFT at 2nd light onto LAKE DRIVE.
- Take FIRST DRIVE on the RIGHT.
- We are in the building behind Lake Michigan Credit Union.

Office Address: Partners in Plastic Surgery
4070 Lake Drive Suite 202
Grand Rapids, MI  49546
(616) 464-4420