

PLEASE PRINT FORMS. FILL OUT. AND BRING WITH YOU TO OFFICE FOR YOUR VISIT!

Cosmetic Surgery Center

5121 Greenwich Road
Virginia Beach, VA 23462
www.drjoannelopes.com

Patient Name: _____ Today's Date: _____

Address: _____

City/State/Zip: _____

Employer: _____ Occupation: _____

Employer Phone: _____ Ext _____

Appointment Confirmation Phone Number: _____ (H): _____

(C) _____ (W) _____

Email Address _____ Social Security # _____

Date of Birth: ____/____/____ Age: _____ Sex: M F Marital Status: S M D W

Primary Care Physician: _____ Phone: _____

How were you referred to our office? _____

In case of Emergency, who should be notified? _____ Phone: _____

Do we have your permission to:

Leave a message on your answering machine at home? Yes No

Leave a message at your place of employment? Yes No

Discuss your medical condition with any member of your household? Yes No

If yes, Whom: _____ Relationship: _____

~Responsible Party (if under age of 18):

Name: _____ Relationship to Patient: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Insurance Information

**please give all insurance information/cards to receptionist for copying
if procedure will be covered by insurance.*

Do you require a REFERRAL for this visit? _____

Primary Insurance Name _____

Ins. Address _____

Name of Insured _____

Insured's Id # _____

Insured's Date of Birth: _____

Group # _____

Relationship of patient to insured: _____

Assignment of Benefits and Release of Information:

I hereby authorize any member of the office of Dr. JoAnne Lopes and/or their designates to provide medical treatment, release of information pertaining to treatment for insurance purposes, and to receive direct insurance payments for professional treatment otherwise payable to me for services rendered, unless payment arrangements have been established. The undersign agrees to be responsible for valid referral forms, required by their managed care carrier, or they will be financially responsible for the balance due. The undersign agrees to be responsible for court costs, 25% attorney's fees associated with the collection procedures brought by the office and a \$20.00 return-check charge should they become necessary. If my insurance carrier does not pay my claim, I give Dr. JoAnne Lopes my permission to allow Virginia Insurance Commissioner's office to be contacted on my behalf.

Patient / Responsible Party: _____ Date: _____

Cosmetic Surgery Center
Dr. JoAnne Lopes

Patient Medical History

**Please complete the following questions. All information will be kept confidential, and you will better assist your doctor in decisions regarding your care.*

Name_____ Age_____ Weight_____ Height_____

Name of your primary care physician_____

What brings you to our office? Please be as specific as possible_____

How long have you had this condition?_____

Have you had any previous treatment for this condition?_____

If YES, how and when was this treated?_____

Review of Systems:

Do you have or have you had any of the following? (Please check yes or no)

	YES	NO		YES	NO
Aids or HIV positive			Hepatitis		
Anemia			High Blood Pressure		
Arthritis			Irregular heart beat		
Asthma			Kidney problems		
Back Problems			Migraine Headaches		
Blood clots in legs			Nervous Breakdown		
Blood disorders			Nose/Throat problems		
Bleeding problems			Pneumonia		
Breathing problems			Psychiatric condition		
Cancer			Rheumatic Fever		
Chest pains			Seizures		
Colitis			Shortness of breath		
Diabetes			Skin Cancer		
Ear/ Eye problems			Sleep Apnea		
Epilepsy			Stomach Problems		
Heart problems			Stroke		
Heart murmur			Thyroid Problems		
Heart palpitations			Tuberculosis		
			Transfusion		

Past, Family, and/or Social History:

Current Medical Conditions:_____

Do you have a problem with excessive scarring or keloid formation after being cut? YES NO

Is your general health good? YES NO

Have you ever had psychiatric problems, or been under the care of a psychiatrist, psychologist, or mental health counselor? YES NO
 Do you currently Smoke: YES NO If yes, how many packs per day? _____
 How many years? ___ Have you ever smoked? _____ If yes, when? _____
 Do you drink alcohol? YES NO If yes, how much? _____ how often? _____
 Do you have any relatives who have had breast cancer? YES NO If yes, who? _____
 Have you ever had a mammogram? YES NO If yes, when? _____
 Have you or a relative ever had a blood clot? YES NO If yes, explain _____

Have you had exposure to any of the following?
 Radiation YES NO
 Excessive sun YES NO
 Are you pregnant? YES NO Last menstrual period? _____

List all medications you are currently taking or have recently been taking. Include the does and frequency. Be sure to include aspirin, blood thinners, cortisone, vitamins, birth control, and over the counter drugs.

Medications	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any allergies to food, drugs, or latex _____

List any previous surgeries, including the year, type of anesthesia, and if any reactions occurred, Please include any child births as well.

Previous Surgery	Year	Anesthesia Type/Reactions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The above is correct to the best of my knowledge.

Patient signature _____ Date _____