EDWARD EADES, M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY

PATIENT INFORMATION

Full Name:_____ Married___ Single___

Spouse's name_____

Address:_____

City:_____ State:_____ Zip:_____

E-Mail:_____

Phone: (_____)_____

Work phone: (_____)_____

Cell phone: (_____)_____

Birth Date:_____ Male__ Female__ Referred by:_____

Social Security #:_____

Patient's Employer:_____

Patient's Permanent Address (if different):

_____

City:_____ State:_____ Zip:_____

Emergency Notification:

Name:_____Phone:_____Relationship:_____

GUARANTOR INFORMATION (For a minor, or if other than the patient)

Name:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Phone:(____)_____

Employer's

Name:_____Address:_____

City:_____ State:_____ Zip:_____

Phone:(____)_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby assign my insurance benefits to be paid directly to Edward Eades, M.D. I am financially responsible for non-covered services. I also authorize Edward Eades, M.D. to release any information required to process my claims.

Patient Signature:_____Date:_____/_____/_____

Guardian Signature:_____Date:_____/_____/_____

MEDICAL HISTORY QUESTIONNAIRE

1. **Circle 'yes' or 'no' if any of the medical problems listed below apply to you (past or present).**

Heart disease	yes	no	Stomach ulcers	yes	no
High blood pressure	yes	no	Kidney problems	yes	no
Chest pain	yes	no	Diabetes	yes	no
Previous heart attack	yes	no	Thyroid disease	yes	no
Pacemaker	yes	no	Sinus trouble	yes	no
Mitral valve prolapse	yes	no	Seizures	yes	no
Rheumatic fever	yes	no	Migraine headache	yes	no
Heart murmur	yes	no	Arthritis	yes	no
Blood clots in legs	yes	no	Artificial joints	yes	no
Breathing problems	yes	no	Cancer	yes	no
Chronic cough	yes	no	Herpes/Shingles	yes	no
Hepatitis	yes	no	Lupus	yes	no

2. **Please list any additional medical conditions you may have:**

_____

_____

_____

3. **Do you smoke? yes no If yes, how much?**_____

4. **Do you have drug allergies to any medications, ointments, foods, etc. (include description of type of allergic reaction)?**

_____

_____

_____

5. **Please list any surgeries you may have had:**

_____

_____

_____

6. **Do any members of your biological family have bleeding tendencies or problems with local or general anesthetics? yes no**

   If yes, please explain:

   _____

   _____

7. **Please list all medications (and dosages):**

	Medication	**Dose(mg, iu, etc)**	**Times per day**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

8. **Height: _____ Weight: _____**

Patient Signature:_____ Date:_____