PATIENT REGISTRATION FORM

Cosmetic Surgeons of Michigan, PC
George T. Goffas, M.D.

The following information will help us to serve you better. Please make every effort to fill out the information fully and accurately. Please be sure to complete both sides of the form. Your responses are held strictly confidential.

PERSONAL INFORMATION

Name _____

Date of Birth _____ Age _____ Sex _____ SS# _____

Home Address _____

City _____ State _____ Zip _____

Phone Home _____ Work _____

Email _____

❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed

Where employed? _____ Occupation? _____

Education - *highest year completed* _____

Name of spouse (if married) _____ how many children _____

Spouse's occupation _____

Spouse's employer _____

In case of emergency, contact: _____ Relationship: _____ Phone _____

Who is responsible for charges? _____

HIPAA and INSURANCE INFORMATION

We offer review of your HIPAA rights and by your signature you acknowledge receipt of such information. Although insurance usually does not cover the cost of cosmetic surgery, there are many instances in which coverage is applicable. If you feel that your treatment might be covered, please fill in the following:

Company _____ Insured Name _____

Gp # _____ Policy # _____

Please circle below the type or types of surgery you are interested in discussing:

NOSE	FACE	EYELID	NECK	MOUTH	EARS	SCARS
CHEEKS	CHIN	WRINKLES	BREAST	ABDOMEN	BODY	RECONSTRUCTIVE
LIPOSUCTION	LASER	OTHER _____				

Please use this space to give us any other information you feel would be helpful for your consultation.

WHY DID YOU SELECT OUR CENTER - *Please indicate all that apply*

❒ General reputation or recommendation

❒ Patient referral. May we ask who? _____ May we acknowledge referral? ❒ Yes ❒ No

❒ Doctor referral. May we ask who? _____ May we acknowledge referral? ❒ Yes ❒ No

❒ Speaking engagement. Where? _____ ❒ Magazine - Which? _____

❒ Newspaper ❒ Yellow Pages ❒ Website - Which? _____

❒ Other _____

The medical history is an extremely important part of your consultation. It helps to alert us to any potential problems that might interfere with your surgery. Please take the time to fill this out completely and accurately. If you need some help, the staff will be glad to assist you.

Please continue on other side

Continued from previous side

List all prescription drugs you are taking: _____

_____

List any non-prescription drugs you take (i.e., aspirin, cold tablets, etc.): _____

_____

Please tell us about any serious illnesses you have had in the past

for example: heart disease, blood pressure problems, pulmonary disease, kidney disease, diabetes, thyroid trouble, stomach ulcers, etc.

_____

_____

Please list any operations you have had (including cosmetic surgery). Give approximate dates. _____

_____

_____

Describe any difficulties you have had with anesthesia _____

Describe any injuries you have sustained – include dates _____

Are there any hereditary disorders in your family that might be of significance? _____

List any drugs to which you are allergic _____

Do you smoke? ❒ Yes ❒ No If so, what form and how much? _____

How much alcohol do you drink? ❒ None ❒ occasional ❒ moderate ❒ heavy

How is your general health?_____ Are you under a doctor's care? _____

Please review the list below and check anything applicable. You may use the space to the right for any explanation that you think would be helpful. Please be as complete as possible.

❒ Severe dryness of the eyes
❒ Glaucoma or blurry vision
❒ Recurrent severe dizziness
❒ Severe headaches
❒ Chronic sinus problems or nasal blockage
❒ Recurrent fever blisters
❒ Paralysis of the face
❒ Asthma or emphysema
❒ Chronic hoarseness
❒ Shortness of breath
❒ Chest pain
❒ Heart disease or high blood pressure
❒ Chronic abdominal problems
❒ Kidney or bladder problems
❒ Blood in bowel movements
❒ Blood in urine or trouble urinating
❒ Bleeding disorders, (you or anyone in your family)
❒ Easy bruising
❒ Menstrual disorder
❒ Abnormal lump or node
❒ Problems with bones or joints
❒ Unexplained weight loss
❒ Cancer
❒ Emotional problems
❒ Chronic skin condition
❒ Complications after surgery
❒ Bad surgical result or unsatisfactory medical care

HEIGHT _____

WEIGHT_____

MEDICATIONS

Name	Dose	Freq.

Date this form completed _____ Signature _____