ACCURATE AESTHETICS PLASTIC SURGERY
1 WASHINGTON ST., #301, WELLESLEY, MA 02481

Phone **781-263-0011**
Fax **781-263-0096**

(PLEASE COMPLETE ALL ITEMS AND PRINT)

DATE _____

Male ❑ Female ❑

PATIENT INFORMATION

Patient's Name _____ Age _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Married ❑ Single ❑ Widow(er) ❑ Divorced ❑ Separated ❑

Cell Phone _____

E-Mail _____ Social Security Number _____

Patient's Occupation _____ Patient's Employer _____

Business Address _____ City _____ Business Phone _____ Ext. _____

Primary Care Physician _____ Address _____ Phone _____

Patient Referred By _____ Address _____

Has this office previously treated any member of your family? Yes ❑ No ❑ If Yes, whom _____

Nearest relative not living with you _____
NAME RELATIONSHIP

Address _____ Telephone No. _____

Pharmacy _____ Address _____ Telephone No. _____

FINANCIAL RESPONSIBILITY

My bill will be paid by: Patient ❑ Spouse ❑ Father ❑ Mother ❑ Other ❑ _____
(SPECIFY)

Name of Spouse/Parent _____ Spouse/Parent's Occupation _____

Spouse/Parent's Employer _____ Employer's Address _____

Business Phone _____ Ext. _____

If Other, name and address _____

HEALTH INSURANCE

Insurance Co. _____ Certificate No. _____ Subscriber's Name _____

WHEN AN ATTORNEY IS INVOLVED

Attorney's Name _____

Address _____ Phone _____

PATIENT INFORMATION

DO NOT WRITE BELOW

What is the reason for coming to the office?

_____

_____

_____

_____

IF INJURY, Date _____

PAST MEDICAL HISTORY

Height _____ Present Weight _____

Any weight loss? Yes ❑ No ❑ If Yes, how much _____

PREVIOUS SURGERY AND INJURIES (Please List)

Operation	Year	Complications, if any

MEDICATIONS, DRUGS

Please list **ALL** medications you are now taking (including birth control pills, diuretics (water pills), blood pressure or heart medications, tranquilizers, hormones, steroid medications, cortisone, blood thinners, aspirin, bufferin, herbs, vitamins, supplements) specify dose.

_____

_____

_____

_____

_____

MATERNAL HISTORY

Have you ever been pregnant? Yes ❑ No ❑

If yes, how many times? _____ How many children do you have? _____ Ages: _____

Are you now pregnant? _____ Are you planning more children? Yes ❑ No ❑ Don't know ❑

Last Mammogram Date _____ Result _____ Where done _____

GENERAL

Are you allergic to any pills, drugs, medicines or latex? Yes ❑ No ❑ If yes, Comment _____

Have you ever had a bad reaction to **GENERAL or LOCAL** anesthetic? Yes ❑ No ❑ _____

Has a family member ever had a bad reaction to anesthesia? Yes ❑ No ❑ _____

Do you have high blood pressure? Yes ❑ No ❑ _____

Do you bleed unusually easily (from cuts, surgery)? Yes ❑ No ❑ _____

Do you form large scars or keloids? Yes ❑ No ❑ _____

Do you have frequent infections or boils? Yes ❑ No ❑ _____

Have you ever had any significant emotional problems? Yes ❑ No ❑ _____

Have you ever had psychiatric care? Yes ❑ No ❑ _____

Have you ever been advised to see a psychiatrist? Yes ❑ No ❑ _____

Have you ever seen other plastic surgeons about the SAME problem which brings you here? Yes ❑ No ❑ How Many? _____

Are you a smoker? Yes ❑ No ❑ How Much? _____

Do you drink alcohol? Yes ❑ No ❑ How Much? _____

Do you have heartburn or Reflux? Yes ❑ No ❑ _____

LOCAL PROBLEMS

Have you had any illnesses of the following? (Circle if YES)

Brain	Nose	Heart	Blood	HIV or AIDS
Eyes	Breasts	Abdomen	Reproduction	Endocrine (Diabetes)
Ears	Lungs	Urinary	Nervous	Other

If circled, please explain: _____

_____

_____

AUTHORIZATIONS FOR TREATMENT AND PAYMENT

I hereby consent to my examination and treatment in the office of Dr. William E. LoVerme. In addition, I consent to the photographing of all appropriate portions of my body for medical, scientific or educational purposes. I authorize the doctor to obtain from other hospitals and physicians, records of my medical treatment.

I understand that treatment for my medical condition is strictly between the doctor and myself. I understand that the doctor's office will assist me in filling out insurance forms, that if the insurance does not pay, for any reason, I am responsible for the bill. In addition, I understand that I am responsible for any balance of the bill that the insurance does not pay.

I authorize the release of any medical information necessary to process the claim and request payment of benefits to William E. LoVerme, M.D.

I hereby instruct any attorney working with my claim to withhold from any settlement, payment or judgement they receive on my behalf the amount of the bill owed to William E. LoVerme, M.D. for medical and surgical services he has rendered to me and to forward this amount directly to him.

SIGNATURE _____ Relationship to Patient (Self, Mother, etc.) _____