Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes **Email:** _____

Contact Restrictions: _____

Age _____ Birthdate _____ SS# _____ Gender: **M** **F**

Marital Status ❒ Single ❒ Married/Partner _____ ❒ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

How did you hear about Kurtzman Plastic Surgery?

❒ TV News ❒ TV Ad ❒ Phone Book ❒ Magazine ❒ Newsletter ❒ Radio ❒ Salon ❒ Web

❒ Friend/Relative: _____ ❒ **Doctor**: _____ ❒ Other: _____

If you were referred by a specific person, may we thank them? ❒ Yes ❒ No

Emergency Contact

_____ Relationship to Patient _____

Contact Phone Number: _____ _____ _____

Primary Care Physician: _____

Areas of Interest: (mark all that apply)

Facial Procedures

❒ Blepharoplasty (Eyelid Lift)
❒ Botox
❒ Brow or Forehead Lift
❒ Earlobe Repair
❒ Facial Liposuction (Neck, Jowls)
❒ Face or Neck Lift
❒ Lip Enhancement
❒ Otoplasty (Ear Pinning)
❒ Rhinoplasty (Nose Reshaping)
❒ Skin Resurfacing (Peel, Etc.)
❒ Wrinkle Fillers (Injections)

Breast Procedures

❒ Breast Augmentation
❒ Breast Reconstruction
❒ Breast Reduction
❒ Mastopexy (Breast Lift)
❒ Nipple Reduction or Inversion
❒ Abdominoplasty (Tummy Tuck)
❒ Brachioplasty (Arm Lift)
❒ Full Body Lift
❒ Liposuction (Thighs, Abdomen, Etc.)
Labiaplasty: _____

Skin Procedures

❒ Skin Care
❒ ViPeel/Radiance Peel
❒ Obagi Products
❒ Makeup Demonstration
❒ Microdermabrasion
❒ Sun/Age Spot Concerns
❒ Lesions / Moles

Implants: Area interested in:

_____

I understand that office visit charges are **payable on the day service is rendered**.

Signature _____ **Date** _____

Would you like a complimentary skin evaluation? ❒ Yes ❒ No

KURTZMAN PLASTIC SURGERY

513-891-4440

Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Name: _____ Reason for Visit: _____

Age: _____ Height: _____ Feet _____ Inches Weight: _____ Lbs.

Current Physician(s): _____

List all Surgeries (Hospitalization and the Date of Occurrence):

List any Serious Illnesses and/or Accidents:

Do you have or have you had any of the following: (circle for each, give date occurred if Yes)

Abnormal Bleeding	No	Yes	Exzema	No	Yes	MRSA	No	Yes
Anesthesia Problems	No	Yes	Heart Disease	No	Yes	Skin Cancer	No	Yes
Asthma	No	Yes	Heart Murmur	No	Yes	STD	No	Yes
Breast Cancer	No	Yes	Hepatitis	No	Yes	Stroke	No	Yes
Breast Cyst	No	Yes	High Blood Pressure	No	Yes	Thrombo-embolism	No	Yes
Cancer	No	Yes	HIV	No	Yes	Thyroid Disorder	No	Yes
Chest Pain/tightness	No	Yes	Hives	No	Yes	Tuberculosis	No	Yes
Depression	No	Yes	Kidney Stones	No	Yes	Ulcers	No	Yes
Diabetes	No	Yes	Mitral Valve Prolapse	No	Yes			

Do you smoke? No Yes If yes, how much? _____ Pack(s)/day How long? _____ Years

Do you drink alcohol? No Yes If yes, how much? _____ How often? _____

# of Pregnancies _____

#of Children _____

Do you use recreational drugs? No Yes If yes, describe: _____

Do you have bleeding or bruising problems? No Yes If yes, describe: _____

Do you have problems with scarring? No Yes If yes, describe: _____

Do you have any history of problems with anesthesia? No Yes If yes, describe: _____

List the name of all medications you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency.

List ALL drug and/or latex allergies.

The above information is accurate and complete to the best of my knowledge.

Signature _____ **Date** _____

kurtzman
PLASTIC SURGERY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(you may refuse to sign this document)

I, _____ have received a copy of this office's Notice of Privacy Practices.

Please print name: _____

Signature: _____

Date: _____

For office use only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communication barrier prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (please specify)

I hereby give my consent for Kurtzman Plastic Surgery to release my protected health information to the following family members/friends

Name:_____Relationship to Patient_____
Name:_____Relationship to Patient_____
Name:_____Relationship to Patient_____
Name:_____Relationship to Patient_____
