COEUR D'ALENE PLASTIC SURGERY

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BOARD-CERTIFIED PLASTIC & RECONSTRUCTIVE SURGEON
1875 N Lakewood Drive, Suite 200 | Coeur d'Alene, Idaho 83814

RECONSTRUCTIVE INTAKE FORM | PERSONAL DEMOGRAPHIC INFORMATION

NAME: _____ DATE: _____
LAST FIRST MIDDLE

S.S.N. ☐☐☐ ☐☐ ☐☐☐☐ BIRTH DATE: / / AGE: GENDER: M / F

MAILING ADDRESS: _____
STREET CITY STATE ZIP CODE

PHONE: _____ _____ EMAIL ADDRESS: _____
HOME CELL

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED/SEPARATED ☐ WIDOWED

SPOUSE (IF APPLICABLE): _____
NAME BIRTH DATE

PREFERRED LANGUAGE: ☐ ENGLISH ☐ OTHER _____

RACE: ☐ AMERICAN-INDIAN ☐ BLACK/AFRICAN-AMERICAN ☐ WHITE ☐ OTHER _____ ☐ DECLINED

ETHNICITY: ☐ CENTRAL-AMERICAN ☐ HISPANIC / LATINO / SPANISH ☐ OTHER _____ ☐ DECLINED

INSURANCE INFORMATION

PRIMARY INSURANCE COVERAGE:

_____ _____ _____
NAME OF CARRIER POLICY NUMBER GROUP NUMBER

_____ _____ _____
SUBSCRIBERS NAME & PATIENT RELATIONSHIP SUBSCRIBER D.O.B. INSURANCE PHONE NUMBER

SECONDARY INSURANCE COVERAGE:

_____ _____ _____
NAME OF CARRIER POLICY NUMBER GROUP NUMBER

_____ _____ _____
SUBSCRIBERS NAME & PATIENT RELATIONSHIP SUBSCRIBER D.O.B. INSURANCE PHONE NUMBER

GUARANTOR INFORMATION (IF UNDER 18) : _____ _____
NAME PHONE

EMPLOYMENT INFORMATION: _____
EMPLOYER'S NAME ADDRESS

_____
PATIENT NAME

CONTINUED ON NEXT PAGE ➔

COEUR D'ALENE PLASTIC SURGERY

PATIENT INFORMATION, CONTINUED

1. HOW DID YOU LEARN ABOUT US OR WHO REFERRED YOU TO CDA PLASTIC SURGERY

INFORMATION SOURCE OR NAME OF REFERRER _____ PHONE _____

2. WHO IS YOUR PRIMARY CARE PHYSICIAN?

NAME OF PHYSICIAN _____ PHONE _____

STREET _____ CITY _____ STATE _____ ZIP _____

3. WHAT PHARMACY DO YOU USE?

NAME OF PHARMACY _____ PHONE _____

STREET _____ CITY _____ STATE _____ ZIP _____

ARE YOU CURRENTLY TAKING ANY NARCOTICS? ☐ YES ☐ NO IF YES, NAME? _____ HOW LONG? _____

I agree the **Coeur d'Alene Plastic Surgery™** may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE: _____

6. PLEASE LIST ALL MEDICATIONS / HERBS / TEAS YOU CURRENTLY USE:

TYPE / NAME _____ FREQUENCY _____ DOSAGE _____

TYPE / NAME _____ FREQUENCY _____ DOSAGE _____

TYPE / NAME _____ FREQUENCY _____ DOSAGE _____

7. DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? ☐ YES ☐ NO

IF YES, PLEASE LIST AND DESCRIBE YOUR REACTION TO THE MEDICATION:

MEDICINE ALLERGY _____ REACTION _____

PATIENT NAME _____

CONTINUED ON NEXT PAGE ➔

8. ARE YOU CURRENTLY OR HAVE YOU EVER HAD PROBLEMS WITH THE FOLLOWING?

	YES	NO		YES	NO
No Past Medical problems reported			Liver Disease		
Anxiety Disorder			Low Back Pain		
Arthritis: Type?			Neck Pain		
Asthma			Mid Back Pain		
Bleeding Disorder			Radiculopathy — Upper		
Blood Clots (Deep Vain Thrombosis)			Radiculopathy — Lower		
Cancer: Type?			Organ Transplant		
CHF			Osteopenia		
Claustrophobic			Osteoporosis		
Coronary Artery Disease			Other Lung Disease		
COPD			Poliomyelitis		
Diabetes Type I			Peripheral Vascular Problem		
Diabetes Type II			Pulmonary Embolism		
Dialysis			Reflux Disease		
Diverticulitis			Rheumatoid Arthritis		
Fibromyalgia			Sciatica		
Gout			Stroke		
Pacemaker			Tuberculosis (TB)		
Heart Arrhythmia			Ulcers		
Heart Attach (MI)			Urinary Tract Infection		
Heart Murmur			Other:		
Hiatal Hernia			Problems with Anesthesia		
HIV or AIDS			Hepatitis		
Hypertension			Hypercholesterolemia		
Hyperthyroidism			Leg / Foot Ulcers		
IBS (Irritable Bowel Syndrome)			Kidney Disease		
Kidney Stones					

9. ARE YOU ALLERGIC TO LATEX OR TAPE? ☐ YES ☐ NO

10. HAVE YOU EVER HAD MRSA? ☐ YES ☐ NO

11. HAVE YOU EVER HAD HEPATITIS C or B? ☐ YES ☐ NO

12. DO YOU DRINK ALCOHOL? ☐ YES ☐ NO IF YES, HOW MANY DRINKS/WEEK? _____

13. DO YOU SMOKE? ☐ YES ☐ NO IF YES, PACKS/DAY? _____ HOW LONG? _____

CONTINUED ON NEXT PAGE ➔

_____
PATIENT NAME

PATIENT INFORMATION, CONTINUED

14. PLEASE ANSWER THE FOLLOWING QUESTIONS: DO YOU . . .

HAVE CHILDREN? ☐ YES ☐ NO IF YES, HOW MANY? TYPE OF DELIVERY? BREAST FEED?

LIVE ALONE? ☐ YES ☐ NO IF NO, WITH WHOM? _____

USE A SPECIAL DIET? ☐ YES ☐ NO DESCRIBE _____

USE RECREATIONAL DRUGS? ☐ YES ☐ NO DESCRIBE _____

EXERCISE REGULARLY? ☐ YES ☐ NO HOW OFTEN? _____

SPORTS OR HOBBIES? ☐ YES ☐ NO DESCRIBE? _____

15. PLEASE LIST ALL PAST SURGERIES AND HOSPITALIZATIONS:

SURGERY / HOSPITALIZATION	DATE	PHYSICIAN / SURGEON

16. HAVE YOU EVER HAD PROBLEMS WITH GENERAL ANESTHESIA? ☐ YES ☐ NO

17. FAMILY HISTORY

FAMILY MEMBER	IF ALIVE, AGE & HEALTH STATUS	IF DECEASED, AGE AT TIME OF DEATH & CAUSE
FATHER		
MOTHER		
SIBLING		
SIBLING		
AUNTS		
UNCLES		

PATIENT NAME

CONTINUED ON NEXT PAGE ➔

PATIENT INFORMATION, CONTINUED

18. CURRENT VITALS:

HEIGHT	WEIGHT	BRA SIZE

18. CHIEF COMPLAINT / CURRENT CONCERN:

Describe your chief reason for desiring reconstruction: _____

_____

_____

How long have you had this desire? _____

How often (day/week or month) do you think about reconstruction? _____

Was this a result of an injury? ☐ YES ☐ NO IF YES, WHAT WAS THE DATE OF THE INJURY? _____

If yes, please describe how it happened? _____

_____

_____

Do you have shoulder grooving, skin infections or back pain? ☐ YES ☐ NO

_____ I acknowledge that I have received the **Notice of Privacy Practices** of Coeur d'Alene Plastic Surgery,™ which explains its legal duties and privacy practices with respect to my protected health information.

By signing below, I agree that all the information provided is true to the best of my knowledge. I also hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for the non-covered services. I also authorize the physician to release any information required to process this claim.

PATIENT SIGNATURE	DATE

I have reviewed the above information in detail with the patient.

KATE KUHLMAN-WOOD, MD	DATE