ROBINSON FACIAL PLASTIC SURGERY
Burke Robinson M.D.

PATIENT HEALTH HISTORY

Date: _____

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **PLEASE FILL OUT EVERY ITEM.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name _____First _____MI_____ SSN#_____

Sex ☐ M ☐ F DOB_____/_____/_____ Weight:_____ Height:_____

Pharmacy Contact:_____

Name of Referring Physician _____ Name of Primary Care Physician_____

REASON FOR VISIT TODAY_____

Are you taking ANY kind of medication now? (This includes prescription, topical, over-the-counter or herbal medications)
☐ **No** ☐ **Yes** If yes, please list below. If you run out of room, use the back of this sheet for additional information.
PLEASE LIST ALL MEDICATIONS CURRENTLY BEING USED (PLEASE PRINT NEATLY)

Name of drug	Dosage	How often taken

Have you ever been on Accutane? ☐ **No** ☐ **Yes** If yes, when was your last dose? _____
Are you currently taking Coumadin, aspirin or aspirin containing medications? ☐ **No** ☐ **Yes**

Are you allergic to ANY medication? ☐ **No** ☐ **Yes** If yes, please list below.

Name of Medication	Type of Reaction

NON-MEDICATION ALLERGIES:

Are you allergic to: Latex Gloves? ☐ **No** ☐ **Yes** Tape? ☐ **No** ☐ **Yes** Contrast Dye? ☐ **No** ☐ **Yes**
Are you allergic to any foods? If yes, please describe_____
Have you had any allergy testing in the past? ☐ **No** ☐ **Yes** If yes, which type? Skin tests ☐ Blood tests ☐
Are you currently taking Allergy Shots? ☐ **No** ☐ **Yes**

PAST HEALTH HISTORY:

Have you ever been ***DIAGNOSED*** with any major health problems? Indicate below:

Cancer (type) _____

HEAD and FACE:

Cluster headache	☐ **No**	☐ **Yes**
Migraine headache	☐ **No**	☐ **Yes**

EYES:

Cataracts	☐ **No**	☐ **Yes**
Glaucoma	☐ **No**	☐ **Yes**
Dry Eyes	☐ **No**	☐ **Yes**

EARS:

Hearing loss from aging	☐ **No**	☐ **Yes**
Hearing loss from trauma	☐ **No**	☐ **Yes**
Chronic ear infections	☐ **No**	☐ **Yes**
Meniere's disease	☐ **No**	☐ **Yes**

LUNGS and RESPIRATORY:

Asthma	☐ **No**	☐ **Yes**
Chronic Bronchitis	☐ **No**	☐ **Yes**
Emphysema	☐ **No**	☐ **Yes**

STOMACH and DIGESTIVE:

Gastrointestinal reflux	☐ **No**	☐ **Yes**
Gallbladder inflammation (Cholecystitis)	☐ **No**	☐ **Yes**
Stomach ulcer	☐ **No**	☐ **Yes**

KIDNEY and/or GENDER SPECIFIC:

Endometriosis	☐ **No**	☐ **Yes**
Kidney stones	☐ **No**	☐ **Yes**
Prostate enlargement	☐ **No**	☐ **Yes**
Renal failure	☐ **No**	☐ **Yes**
Are you pregnant?	☐ **No**	☐ **Yes**

BONES, JOINTS and MUSCLES:

Arthritis	☐ **No**	☐ **Yes**
Degenerative bone disease	☐ **No**	☐ **Yes**

SKIN and/or BREASTS:

Psoriasis	☐ **No**	☐ **Yes**
Scleroderma	☐ **No**	☐ **Yes**
Shingles	☐ **No**	☐ **Yes**

NOSE and SINUS:

Nasal Allergies	☐ **No**	☐ **Yes**
Deviated Septum	☐ **No**	☐ **Yes**
Chronic Sinusitis	☐ **No**	☐ **Yes**
Recurrent Sinusitis	☐ **No**	☐ **Yes**

MOUTH and THROAT:

Chronic Tonsillitis	☐ **No**	☐ **Yes**
Recurrent Tonsillitis	☐ **No**	☐ **Yes**
Sleep Apnea	☐ **No**	☐ **Yes**

HEART and BLOOD VESSELS:

Heart Attack	☐ **No**	☐ **Yes**
Hypertension	☐ **No**	☐ **Yes**
Elevated Cholesterol	☐ **No**	☐ **Yes**

BRAIN and NERVOUS SYSTEM:

Epilepsy	☐ **No**	☐ **Yes**
Multiple Sclerosis	☐ **No**	☐ **Yes**
Stroke	☐ **No**	☐ **Yes**

MENTAL and EMOTIONAL HEALTH:

Anorexia	☐ **No**	☐ **Yes**
Anxiety	☐ **No**	☐ **Yes**
Bulimia	☐ **No**	☐ **Yes**
Depression	☐ **No**	☐ **Yes**

GLANDS, HORMONES & SUGAR CONTROL:

Diabetes(unsure of type)	☐ **No**	☐ **Yes**
Diabetes (type I)	☐ **No**	☐ **Yes**
Diabetes (type II)	☐ **No**	☐ **Yes**
Graves Disease	☐ **No**	☐ **Yes**
Thyroid deficiency	☐ **No**	☐ **Yes**
Thyroid excess	☐ **No**	☐ **Yes**

BLOOD and LYMPH NODE:

Anemia (unknown cause)	☐ **No**	☐ **Yes**
Anemia (iron deficiency)	☐ **No**	☐ **Yes**

ALLERGIES, IMMUNE or INFECTIOUS PROBLEMS:

AIDS	☐ **No**	☐ **Yes**
HIV	☐ **No**	☐ **Yes**
Infectious Mononucleosis	☐ **No**	☐ **Yes**

DIAGNOSIS NOT LISTED:_____

SURGERIES AND HOSPITALIZATIONS:

Have you been hospitalized for a medical problem before? ☐ **No** ☐ **Yes**

If yes, list hospitalizations, the reason for admission and the date: _____

Have you ever had surgery? ☐ **No** ☐ **Yes**

If yes, mark any of the following you have had:

Sinus surgery? ☐ **No** ☐ **Yes**, dates:_____ Tonsillectomy? ☐ **No** ☐ **Yes,** date:_____

Facial Plastic Surgery? ☐ **No** ☐ **Yes** If yes, please tell us procedure and dates _____

_____

Other types of surgeries? _____

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ **No** ☐ **Yes**

If yes, please list what sort of problems. _____

SERIOUS INJURIES:

Have you ever had a serious injury such as face, head, neck, back, or other injury? ☐ **No** ☐ **Yes**

If yes, list and describe the type of injury and when it occurred: _____

FAMILY HISTORY:

☐ **No Family History of Significant or Pertinent Health Problems:**

Specific Anesthesia Problem: ☐Mother ☐Father ☐Brother ☐Sister

Head and Face:

Headache ☐Mother ☐Father ☐Brother ☐Sister

Ears:

Hearing Loss before age 20 ☐Mother ☐Father ☐Brother ☐Sister

Hearing Loss after age 20 ☐Mother ☐Father ☐Brother ☐Sister

Nose and Sinus:

Chronic Sinus Disease (had surgery) ☐Mother ☐Father ☐Brother ☐Sister

Chronic Sinus Disease (no surgery) ☐Mother ☐Father ☐Brother ☐Sister

Heart and Blood Vessels:

Heart Disease ☐Mother ☐Father ☐Brother ☐Sister

High Blood Pressure ☐Mother ☐Father ☐Brother ☐Sister

Lungs & Respiratory:

Asthma ☐Mother ☐Father ☐Brother ☐Sister

Lung Cancer ☐Mother ☐Father ☐Brother ☐Sister

Brain and Nervous:

Stroke ☐Mother ☐Father ☐Brother ☐Sister

Blood & Lymph Node Problems:

Bleeding/clotting problems ☐Mother ☐Father ☐Brother ☐Sister

OTHER PERTINENT FAMILY HISTORY:

_____

_____

_____

_____

SOCIAL HISTORY:

Marital Status_____ What is or was your occupation? _____

Check here if you are retired: ☐

Have you ever used tobacco in any form? ☐ **No** ☐ **Yes** If yes, please complete the following:

Type of Tobacco	From year	To year
Cigarettes per day: _____		
Other: (list type) _____		

Have you ever used alcohol in any form? ☐ **No** ☐ **Yes** If yes, please complete the following:

Type of Alcohol	From year	To year
Beers per week:_____		
Wine glasses per week:_____		
Other: (list type) _____		

Do you use drugs recreationally? ☐ **No** ☐ **Yes**

Caffeine use: ☐ None ☐ About 1 cup/day ☐ 2-3 cups/day ☐ 4 or more cups/day ☐ other _____

REVIEW OF SYSTEMS: CHECK any problems you have or have had recently in the following areas:

General health problems: ☐ **No** ☐ **Yes**
(☐ fever ☐ sleeping problems ☐ unintentional weight loss)

Head or Face Problems: ☐ **No** ☐ **Yes**
(☐ headaches ☐ face pain ☐ skin lesions)

Eye Problems: ☐ **No** ☐ **Yes**
(☐ blurred vision ☐ double vision ☐ loss of vision)

Ear Problems: ☐ **No** ☐ **Yes**
(☐ hearing loss ☐ dizziness ☐ ringing)

Nose & Sinus: ☐ **No** ☐ **Yes**
(☐ frequent colds ☐ frequent nosebleeds ☐ frequent runny nose ☐ itchy nose ☐ sinus drainage)

Mouth and Throat: ☐ **No** ☐ **Yes**
(☐ change in voice ☐ snoring ☐ sore throat)

Neck Problems: ☐ **No** ☐ **Yes**
(☐ neck masses or lumps ☐ pain ☐ swollen glands)

Heart or Circulation: ☐ **No** ☐ **Yes**
(☐ fainting ☐ bluish color of lips or nails ☐ chest pain ☐ irregular heartbeat ☐ leg cramps ☐ swelling ankles)

Stomach problems: ☐ **No** ☐ **Yes**
(☐ abdominal pain ☐ diarrhea ☐ heartburn ☐ nausea ☐ vomiting)

Bones, Joints and Muscles: ☐ **No** ☐ **Yes**
(☐ pain in back ☐ painful joints ☐ stiffness ☐ swelling joints)

Brain or Nervous System: ☐ **No** ☐ **Yes**
(☐ change in alertness ☐ loss of consciousness ☐ numbness ☐ seizures ☐ weakness)

Problems with Glands, Hormones: ☐ **No** ☐ **Yes**
(☐ feel cold all the time ☐ feel hot when others are not ☐ increased appetite ☐ increased fatigue ☐ neck has enlarged ☐ unwanted weight change)

Problems with Blood or Lymph nodes: ☐ **No** ☐ **Yes**
(☐ bleeds excessively after injury ☐ bruises easily)

Problems with Allergies: ☐ **No** ☐ **Yes**
(☐ food intolerances ☐ freq sneezing ☐ hives ☐ post nasal drainage ☐ severe reaction to insect bites)

Lung or Respiratory: ☐ **No** ☐ **Yes**
(☐ freq non-productive cough ☐ freq productive cough ☐ shortness of breath ☐ wheezing

Problem not listed: _____

ROBINSON FACIAL PLASTIC SURGERY

Burke Robinson M.D.

Patient's Name: _____ DOB:_____

HIPAA – PRIVACY POLICY

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide our patients the highest quality medical care possible. Patients should not be afraid to provide information to or practice and its physicians and staff for purposes of treatment, payment, and healthcare operations. Our HIPAA policy in its entirety can be obtained through our office. Please let us know if you would like to receive a copy before signing this consent.

OFFICE POLICY ON MANAGED CARE INSURERS

We are pleased to meet the needs of our patients and referring physicians by enrolling with numerous managed care insurance programs. While we are able to provide you with this service, it is extremely difficult to keep track of all the individual requirements of each plan. Even with the same insurance company the plans may differ. Providing quality medical care for our patients is our primary concern, and we are more than willing to provide that care within your insurance contract guidelines if you let us know at each visit what those guidelines are.

Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently provide services, or order services such as lab work or hospitalization that are not covered, we or the medical facility will have no choice but to bill you directly for those charges. All fees submitted and denied by your carrier will become your responsibility.

Our office will file insurance claims for you, however, office visit co pays and deductibles are payable on the day you are seen. Please remember that you are responsible for all fees, regardless of insurance coverage. Some insurance plans require prior authorization. **This is your responsibility**. If we do not receive the authorization in advance, payment is due at the time of service. With your cooperation, you should be able to receive all benefits offered by your insurance plan, and we will be able to concentrate on caring for your medical needs.

AUTHORIZATION – PLEASE INITIAL & SIGN BELOW

_____ I understand HIPAA and its policies.

_____ I have read and understand the office policy stated above and agree to accept responsibility as described.

_____ I authorize the release of medical information necessary to process a claim, to health care professionals requesting consultation, and third party payers responsible for payment of medical and surgical benefits to Robinson Facial Plastic Surgery.

Signature: _____ Date: _____

ALPHARETTA OFFICE: 3400 Old Milton Parkway | Building C, Suite 515 | Alpharetta, GA 30005
ATLANTA OFFICE: 5555 Peachtree Dunwoody Road | Suite 155 | Atlanta, GA 30342
PH: 770.667.3090 | FAX: 678.867.0929 | www.ROBINSONFPS.com

ROBINSON FACIAL PLASTIC SURGERY

Burke Robinson M.D.

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient's Name: _____ DOB:_____
(please print clearly)

Address: _____

_____

Telephone Number: _____ (Home /Cell/ Office)

_____ (Home/Cell/ Office)

I give consent to be contacted at the following email address:

_____@_____

☐ Sign up for our monthly newsletter. You can unsubscribe at any time.

CHECK ONE OF THE FOLLOWING:

_____ When making contact by telephone, please make reasonable efforts to speak only to me.

_____ When making contact by telephone, you may speak with anyone who answers.

_____ When making contact by telephone, please make reasonable efforts to speak to me or the following person(s):

_____

_____

I understand that "reasonable efforts" means the staff of Robinson Facial Plastic Surgery, will ask the name of the person who answers the telephone and will, under reasonable circumstances, assume that the person is telling the truth. I further understand that if any additional costs are incurred by Robinson Facial Plastic Surgery in communicating with me as described above, I must make arrangements to pay those costs before Robinson Facial Plastic Surgery is obligated to communicate as I have requested.

_____ _____

Signature **Date**

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ROBINSON FACIAL PLASTIC SURGERY

Burke Robinson M.D.

FINANCIAL RESPONSIBILITY

Date: _____

Patient Name:_____

(please print)

We are pleased to have you as a patient and will be happy to provide you services as long as you understand and agree to accept responsibility to our financial policy as described below.

All services provided by Dr. Burke Robinson and by his staff, as well as all products are billable and all payments are due at the time of service, with no exceptions. If you are uncertain of the price of a service, it is the patient's responsibility, therefore your responsibility, to ask and to be prepared to make a payment in full.

I have read and understand the office policy stated above and agree to accept responsibility as described.

_____ _____

Patient Signature **Date**

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