GENERAL AND MEDICAL INFORMATION

NAME: _____ DOB: _____ AGE: _____

Reason for visit: _____

Primary Care Physician: _____ Location: _____ Phone: _____

May we contact your physician regarding any medical problems? ☐YES ☐NO

Are you pregnant? ☐YES ☐NO Breastfeeding? ☐YES ☐ NO

Do you smoke? ☐YES ☐ NO If yes, many per day? _____

Do you drink Alcohol? ☐ YES ☐ NO If yes, how often? _____

Please list any surgeries in the past: _____

Any complication from surgery? ☐YES ☐ NO _____

Have you ever had any problems with anesthesia? ☐YES ☐NO

Any current infections? ☐ YES ☐ NO If yes, please explain? _____

History of autoimmune disease? ☐ YES ☐NO If yes, please explain? _____

History of Herpes Simplex/cold sores? ☐ YES ☐ NO

Any bleeding issues/tendencies? ☐ YES ☐NO If yes, please explain? _____

Do you take immune-suppressant medication? ☐ YES ☐ NO If yes, please list: _____

Use of blood thinners (e.g., Aspirin, Aleve, Motrin, Advil, Coumadin, Plavix, fish oil, vitamin E, etc.)? ☐YES ☐ NO

Do you have a facial implant (e.g., chin or cheek)? ☐ YES ☐NO If yes, which one? _____

Have you had any previous aesthetic treatments? ☐ YES ☐NO If yes, please list: _____

ALLERGIES: ☐**NO KNOWN ALLERGIES** ☐**LATEX** **PLEASE LIST BELOW ALL MEDICATIONS:**

Include all prescriptions, over the counter, vitamins, supplements, and herbal or natural medications taken routinely.

Allergy:	Adverse Reaction:	Allergy:	Adverse Reaction:

	Medication Name	Dose	Route	Frequency

Please answer yes or no to the following and indicate if you or any family members (specify) have been affected by condition.

	Hypertension			Mitral Valve Prolapse			Asthma	
	Heart Murmur			Herpes/Cold Sore			Diabetes	
	Pace Maker			Skin Cancer			Stroke	
	Hepatitis A/B/C			Heartburn			GI Upset	
	Depression			Excessive Bruising			Thyroid	
	Arthritis			Excessive Scarring			Tuberculosis	
	Angina			Excessive Bleeding			Anemia	
	Seizures			Pulmonary Disorders			Headaches	

IN CASE OF EMERGENCY: _____ No: _____ Relation: _____

Pharmacy: _____ **Address:** _____ **No:** _____

Medicare Authorization

I request that payment of authorized Medicare Benefit be made on behalf of Dr. Edwin Williams III M.D., F.A.C.S. for any services furnished to myself by the above physician. I authorize any holder of medical information about myself to release to Health Care Administration and its agent any information needed to determine these benefits payable for related services. I understand my signature requests payment and authorizes' release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted forms, my signature authorized releasing of the information to the determination of Medicare carrier as the full charge. The patient is responsible the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: _____ Date: _____

Assignment and Release

I understand, I have insurance coverage with _____ and assign directly to Dr. Edwin Williams III M.D., F.A.C.S. all medical benefits. If otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured / Guardian: _____ Date: _____