# ATHERTON PLASTIC SURGERY

**Jane S. Weston, M.D., F.A.C.S.**

How were you referred to our office?_____

What type of service or consultation are you interested in?_____

Dr./Mr./Mrs./Ms., Name:_____ Date of Birth: _____Age:_____

Address:_____

City/State:_____Zip_____

Home Phone: (_____) _____ Work Phone (____) _____

Cell (____) _____Email Address:_____

Preferred Pharmacy:_____ City_____Ph.#_____

May we contact you by phone with reminder calls on office visits, pre-operative instructions, etc? Yes No

If yes, what telephone number do you wish to use? _____

If you are not available, may we leave a message with the person/voicemail answering the phone? Yes No

May we contact you by email with reminder calls, office updates, or requested information? Yes No

Employer: _____

Employer Address: _____
Street City State Zip

Primary Physician: _____City:_____

Person to contact in case of any emergencies:_____ Phone (___)_____

Insurance Name: _____Address:_____
City/State/Zip_____
Policy #_____Group #_____Phone#_____

**FINANCIAL RESPONSIBILITY – ASSIGNMENT OF BENEFITS**

I AUTHORIZE The Atherton Plastic Surgery Center to release any and all medical information to the applicable insurance carrier(s). I authorize payment be made directly to Atherton Plastic Surgery Center of all benefits payable to me under the terms of my policy for the professional services, laboratory, and facility fees (including laser, instruments, implants, garment, etc.) It is understood that any payment received above indebtedness will be refunded to me when my bill is paid in full.

I FURTHER UNDERSTAND that should my insurance carrier fail to either pay the full amount of the charges, or deny the claim entirely, I am personally responsible for the balance of all charges.

IT IS ALSO UNDERSTOOD that all procedures not covered by insurance (Cosmetic) will be my sole responsibility. (This includes all consultations).

THIS AUTHORIZATION shall remain valid and effective from the date of signing until revoked in writing and photocopy of this form shall be deemed as valid as the original.

**RECEIPT OF PRIVACY NOTICE**

I acknowledge that I have received the Privacy Notice for Jane S. Weston, M.D./Atherton Plastic Surgery

Patient/Guardian_____Date:_____

# HEALTH QUESTIONNAIRE

Why are you seeing the Doctor today and how long have you had these symptoms?

_____

List all drugs you are currently taking:_____

_____

Have you taken any aspirin in the last two weeks? Yes ( ) No ( )

Allergies:

| | Yes | No | Effect |
|---|---|---|---|
| Penicillin…….. | ___ | ___ | _____ |
| Other Medicine……. | ___ | ___ | _____ |
| _____ | ___ | ___ | _____ |
| Iodine…… | ___ | ___ | _____ |
| Shell Food……. | ___ | ___ | _____ |

| | Yes | No | Effect |
|---|---|---|---|
| Tape…… | ___ | ___ | _____ |
| Hay Fever….. | ___ | ___ | _____ |
| Contact Allergy | ___ | ___ | _____ |
| Food…… | ___ | ___ | _____ |

List all medicine allergies and effects: _____

_____

## LIST ALL HOSPITALIZATION, OPERATIONS (INCLUDING PLASTIC SURGERY) AND SERIOUS INJURIES:

| YEAR | HOSPITALIZATION – OPERATION- INJURY | HOSPITAL & LOCATION |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## ILLNESS & MEDICAL PROBLEMS

| | Yes | No |
|---|---|---|
| Dizzy Spells…….. | _____ | _____ |
| Glaucoma…….. | _____ | _____ |
| Other Eye Problems……. | _____ | _____ |
| _____ | | |
| Ear Trouble…….. | _____ | _____ |
| Sinus Trouble…….. | _____ | _____ |
| Deafness……... | _____ | _____ |
| Decreased Hearing…….. | _____ | _____ |
| Repeated Nosebleeds……. | _____ | _____ |
| Chronic Nose Obstruction | _____ | _____ |
| Swelling in Neck…… | _____ | _____ |
| Asthma…….. | _____ | _____ |
| Bronchitis……. | _____ | _____ |
| Emphysema…….. | _____ | _____ |
| Pneumonia…… | _____ | _____ |
| Tuberculosis…… | _____ | _____ |
| Other Lung Problems…….. | _____ | _____ |
| _____ | | |
| High Blood Pressure…… | _____ | _____ |

| | Yes | No |
|---|---|---|
| Low Blood Pressure…… | _____ | _____ |
| Bleed Easily…… | _____ | _____ |
| Bruise Easily……. | _____ | _____ |
| Bleeding Disorder…… | _____ | _____ |
| Anemia…… | _____ | _____ |
| Heart Attack…… | _____ | _____ |
| Heart Murmur…… | _____ | _____ |
| Other Heart Condition… | _____ | _____ |
| Ankles Swell…… | _____ | _____ |
| Stomach/Duodenal……. | _____ | _____ |
| Ulcer…….. | _____ | _____ |
| Colitis…… | _____ | _____ |
| Diverticulosis…… | _____ | _____ |
| Other bowel problems.. | _____ | _____ |
| Hepatitis…… | _____ | _____ |
| Monocucleosis…….. | _____ | _____ |
| Gall Bladder Trouble… | _____ | _____ |
| Stroke…… | _____ | _____ |
| Convulsions/Seizures… | _____ | _____ |
| Scarlet Fever…… | _____ | _____ |

| | Yes | No |
|---|---|---|
| Arthritis…….. | _____ | _____ |
| Diabetes……. | _____ | _____ |
| Trouble w/anesthesia…… | _____ | |
| Paralysis…….. | _____ | _____ |
| Cancer…….. | _____ | _____ |
| Year and type of Cancer:_____ | | |
| _____ | | |
| WOMEN ONLY: | | |
| Tender Breast…… | _____ | _____ |
| Discharge from Nipples. | _____ | _____ |
| Lumps or recent change in size…….. | _____ | _____ |
| Fibrocystic Disease….. | _____ | _____ |
| Previous Mammograms Year:_____ | _____ | _____ |
| Menstrual Problems…. | _____ | _____ |
| Age of 1st pregnancy_____ | | |
| Were your children breastfed……. | _____ | _____ |

## FAMILY HISTORY:

| | | |
|---|---|---|
| Tuberculosis…… ____ ____ | Diabetes……. ____ ____ | Low Blood Pressure……. ____ ____ |
| Asthma…… ____ ____ | Rheumatoid Arthritis…. ____ ____ | Bleeding Tendency…….. ____ ____ |
| Glaucoma…… ____ ____ | Heart Disease…… ____ ____ | Blood Disorders…….. …… ____ ____ |
| Cancer…… ____ ____ | High Blood Pressure…… ____ ____ | (Sickle Cell Anemia, etc.) |

If any Family History marked yes, please explain relation and type of cancer: _____

_____

JANE S. WESTON, M.D., F.A.C.S.
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Atherton, Ca 94027

# CONSENT TO TAKING OF PHOTOGRAPHS

Patient:_____ Date:_____

In connection with the medical services which I am receiving from my physician, Dr. Jane Weston or medical provider, I consent to the taking of photographs of me or parts of my body, under the following conditions:

1. The photographs shall be taken by my physician, designated staff or photographer.

2. The photographs shall become a part of my medical record and will be used only for the purpose of my medical care.

_____

Patient Signature Date

_____

Witness Signature Date