YEH
FACIAL PLASTIC SURGERY

Patient Name _____ Phone (H) _____ Phone (W)_____

Address _____ Phone (Cell) _____

City _____ State ____ Zip _____ Email _____

Social Security _____ Preferred Means of Contact: Phone H / W / Cell / Email

Date of Birth _____ Age _____ Sex F M Marital Status _____ Name of Spouse _____

Emergency Contact _____ Your Employer _____

Relationship to you _____ Phone (H) _____ Employer Address _____

Phone (W) _____ (Cell) _____ City _____ State ____ Zip _____

Complete this section only if someone OTHER than the patient is financially responsible:

Name _____ Relationship to you _____

Address _____ Employer _____

City _____ State ____ Zip _____ Social Security # _____

Insurance Information

Are you covered by insurance? ❑ No ❑ Yes If yes, complete all parts that apply to MEDICAL coverage.

Guarantor or Subscriber _____

Patient relation to guarantor _____

Insurance Plan _____ ID# _____ Group # _____

Secondary Plan _____ ID# _____ Group # _____

General Information

How were you referred to us?

- ❑ Friend _____
- ❑ Patient _____
- ❑ Doctor _____
- ❑ Internet _____
- ❑ Magazine/Mail _____
- ❑ Newspaper _____
- ❑ Radio _____
- ❑ Public Seminar _____
- ❑ Other _____

Please indicate the procedure(s) you would like information about during your office visit and consultation.

- ❑ Face Lift
- ❑ Blepharoplasty (Eyelids)
- ❑ Brow Lift
- ❑ Rhinoplasty (nose)
- ❑ Fat Transfer
- ❑ Chin Augmentation
- ❑ Botox / Dysport
- ❑ Fillers
- ❑ Latisse (Eyelash growth)
- ❑ Chemical Peel
- ❑ Skin Care Treatment
- ❑ Repair of torn earlobes
- ❑ Removal of moles, cysts, etc.
- ❑ Scar Revision
- ❑ Other _____

How long have you considered treatment for? _____ Have you ever had Botox/Dysport, or Fillers before? YES NO

Have you had any previous cosmetic surgery? YES NO If so, what? _____

Who performed the surgery? Dr. _____ Were you satisfied with the results? YES NO

If no, why? _____

Has anyone you are close with had a cosmetic procedure? YES NO Who? _____

What procedure was done? _____ When? _____

Have you consulted another doctor in regards to this type of surgery? YES NO

Have you discussed this surgery with your family? YES NO If so, are they agreeable? YES NO

General and Medical Information

Name_____DOB_____Age_____
Reason for visit_____
Primary Care Physician_____ Location_____Phone No._____
Date of last Physical _____
Referring Physician_____Location_____Phone No._____
Cardiologist_____Location_____Phone No._____
Date of Last Visit_____ Date of last EKG _____
Would you object to our contacting your physician regarding any medical problems? **Yes/ No**
Do you have any drug allergies? **Yes/No** Please list drug and type of reaction

_____

Do you have a **LATEX** allergy? **Yes/No**
Please **list all medications,** including birth control, aspirin, all vitamins, supplements/over the counter meds

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Please answer **Yes** or **No** to the following and indicate any family members who 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_____

Are you Pregnant? **Yes/No**
Do you smoke **Yes/No** If yes what and how often_____
Do you drink Alcohol **Yes/ No** if yes, how often_____
Do you use recreational drugs or steroids **Yes/ No** if yes, what and how often

_____
Please list any surgeries in the past?_____
Any complications from surgery? **Yes/No** _____
Have you ever had any problems with anesthesia? **Yes/No**

_____
Are you involved in any weight loss programs or taking diet pills? **Yes/No**_____

In case of emergency, Contact name_____ No._____Relation_____

Medicare Authorization

I request that payment of authorized Medicare Benefit be made on behalf of Dr. Cory Yeh, M.D. 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. Cory Yeh, M.D.
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**_____