Thank you for choosing us for your medical care. Please arrive 30 minutes early.

Our office is located at 3200 Troup Hwy. Suite 240, Tyler, Texas.

****If for any reason you are unable to keep your appointment please place a courtesy call to our office at least 24 hours prior at 903.606.8888(our phone is answered 24 hours each day)****

We ask that you bring the following information at the time of this visit:

Insurance cards (if applicable)
Driver's license (if applicable)
List of medications you are currently on, with amount you take and frequency
List of known allergies
The enclosed forms, completed in their entirety in blue or black ink only

If you have any questions about your insurance covering your visit to our office (if applicable), you will need to contact them prior to your visit. Payment in full is expected at the time of the visit if you do not supply us with complete insurance information, or if there are no benefits available for our services. If you do have insurance coverage, payment of any applicable co-pays or responsible amounts will be expected at the time of service. For your convenience we accept cash, checks, Visa, MasterCard, Discover and American Express. If you have any questions, please feel free to contact us. We look forward to seeing you on the above date.

The Office Staff of the Center for Cosmetic Surgery

Center for Cosmetic Surgery

PERSONAL DATA:

Full name: ____ Date of birth: ______________

Social Security Number: _______________________

Address: ____ City: ______________ State: ______ Zip:_______

Cell phone: ________________________ Home phone: ___________________ Work phone: ______________

Email address: ____

EMPLOYER INFORMATION:

Patient Employer:____ Occupation: __________________________

EMERGENCY CONTACT:

Name: ___________________________________ Date of birth: ______________

Relation to patient: ___________________________

Cell phone: _________________ Secondary phone: ___________________

AUTHORIZATION FOR IMAGING AND CONSENT FOR USE OF MEDICAL RECORDS

Patient Identification

I hereby authorize **James D. Saar, MD, FACS and/or Laura E. O'Halloran, MD** to use photographs, digital images, video images, computer images, slides, illustrations or other "imaging records" made of me in any manner he/she considers proper in my care and treatment and in order to further medical education and training, in publications or in instructional situations. It is understood and agreed that my name will not be used, or in any way be disclosed in connection with any public use of this material.

I agree and understand that these imaging records are maintained as part of the medical record.

I grant this consent as a voluntary contribution, hereby waiving any and all rights I may have to royalties or other compensation, if any, in connection with any such use, and indemnify and hold harmless the CHRISTUS Trinity Clinic, the CHRISTUS Trinity Mother Frances Health System, and CHRISTUS Trinity Mother Frances Hospital, their respective affiliates and subsidiaries and officers, directors, members, physicians, surgeons, and other employees from and against any and all claims, demands, or liability of any nature whatsoever regarding use of the imaging records for the above-referenced purposes.

I hereby confirm that I have read and fully understand the above prior to signing.

DATE: ________________________________ **TIME:** ________________________________ **A.M. / P.M.**

____
Patient/Legally Responsible Person Signature

WITNESS:

____	3200 Troup Highway, Suite 240
Signature	**Address (Street or PO Box)**
____	Tyler, Texas 75701
Name (Print)	**City, State, Zip Code**

Center for Cosmetic Surgery

NAME:____**Age:**_____**Sex: F M** **Height**__________**Weight**_______________
Referred by:_______________________________________**Primary Care Doctor/City**______________________________________
REASON FOR VISIT TODAY: ____
Due to an injury? Y N On the job injury? Y N Auto accident? Y N Date of injury/accident: _________________

PAST MEDICAL HISTORY: (Have you ever had any of the following medical conditions?)

High blood pressure	Y	N	Stomach ulcer or gastritis	Y	N
Heart attack or congestive heart failure	Y	N	Hepatitis or other disorder of the liver	Y	N
Heart murmur or heart valve disorder	Y	N	Kidney disease or renal failure	Y	N
Asthma, bronchitis, COPD or lung disease	Y	N	History of blood clots in the veins of your legs	Y	N
Stroke, TIA or paralysis	Y	N	Anemia or any other blood disorder	Y	N
Diabetes or thyroid disorder	Y	N	Transfusion of blood or blood products	Y	N
Autoimmune disease	Y	N	Glaucoma or other eye disorder	Y	N
Arthritis or degenerative joint disease	Y	N	Seizure disorder	Y	N
Cancer (**What type?**) ____________________	Y	N	History of any psychiatric disorder	Y	N
Have you fallen in the past year?	Y	N	Do you have any significant barriers to learning?	Y	N
Do you feel unsafe returning to your home?	Y	N Decline	Have you seen a plastic surgeon in the past?	Y	N

Any other medical problems? (Be specific): ____

Have you had a mammogram? Y N **Where?**_________________________**When?** ____________________

PAST SURGICAL HISTORY: (List <u>ALL</u> previous surgeries by date including any cosmetic surgery procedures.)

SURGERY	***DATE***	***ANY PROBLEMS WITH THE SURGERY OR ANESTHETIC?***

ALLERGIES: (Reaction to any medication, drug, or anesthetic)

ALLERGIC TO:	***REACTIONS***

MEDICATIONS: (Prescription, herbal, and over-the-counter)

MEDICATIONS:	***DOSE & FREQUENCY***

Preferred pharmacy (Name, City &Telephone #): ____

SOCIAL HISTORY:

Marital status: *S M D W* Number of children: _____ Children at home: ____ Hobbies: ___________________________________
Do you use tobacco? ***Never In the past Occasionally Regularly*** Amount/day: ____________ Number of years: ____________
Do you drink alcohol? ***Never In the past Occasionally Regularly*** Amount/day: ____________ Number of years: ____________

FAMILY HISTORY: (Any history of the following conditions in a blood relative? Which family members?)

High blood pressure	Y	N	________________________	Heart disease	Y	N	______________________________
Diabetes	Y	N	________________________	Stroke	Y	N	______________________________
Cancer ***(What type?)***	Y	N	________________________	Bleeding disorder	Y	N	______________________________

REVIEW OF SYSTEMS: (Have you recently experienced or do you currently experience any of the following symptoms?)

Recent weight loss or easy fatigability	Y	N	Pain or burning when you urinate	Y	N
Fever, chills, or night sweats	Y	N	Pain in your extremities or major joints	Y	N
Change in vision or temporary loss of vision	Y	N	Slow wound healing or excessive scaring	Y	N
Excessive tearing or excessively dry eyes	Y	N	Change in size or color of a mole or other growth	Y	N
Irregular heart rate or palpitations	Y	N	New lumps or discomfort in your breast	Y	N
Tightness, pressure or pain in your chest	Y	N	Dizziness, light-headedness or faintness	Y	N
Swelling of your feet or ankles	Y	N	Weakness in any extremity	Y	N
A recent cold, flu or pneumonia	Y	N	Any unusual stress in your life at this time	Y	N
Wheezing or shortness of breath	Y	N	Any chance that you may be pregnant	Y	N
Heartburn or reflux	Y	N	Excessive or prolonged bleeding when cut	Y	N
Frequent loose stools or constipation	Y	N	Any known deficiency of your immune system	Y	N
Blood in your stool or urine	Y	N	Allergy or reaction to Latex	Y	N