WRIGHT SPELLMAN PLASTIC SURGERY

Harry V. Wright, MD
Board Certified
American Board of Facial Plastic and Reconstructive Surgery
American Board of Otolaryngology Head and Neck Surgery

Andrea J. Spellman, DO
Board Certified
American Osteopathic Board of Otolaryngology/Facial Plastic Surgery

Patient's Name _____
Last **First** **Middle**

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? Yes No _____

E-mail_____ Would you like to receive notifications on events & specials Yes No

Age _____ Birthdate _____ SS# _____ Sex Female Male

Race Caucasian African American Hispanic Asian Other _____ Language Spoken _____ Marital Status: Single ☐Domestic Partner ☐ Widow - Married to: _____

Ethnicity: _____

Primary Physician _____

Referring Physician _____

Preferred Pharmacy (Phone #) _____

Patient's Employer _____ **Occupation** _____

Work Phone _____ Ext _____ Is it okay to call you at work? Yes No

Address _____
Street & Apt # City State Zip

Emergency Contact

_____ **Relationship to Patient** _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

Primary Health Insurance Company _____

Insured Name: _____ **DOB**_____ **SS#** _____

Policy # _____ Group # _____ Ins Phone _____

Referral Required? Yes No Copay? Yes No $_____

Secondary Health Insurance Company _____

Insured Name: _____ **DOB**_____ **SS#** _____

Policy # _____ Group # _____ Ins Phone _____

Referral Required? Yes, No Copay? Yes No $_____

I understand that office visit charges are payable on the day service is rendered. I authorize Wright Spellman Plastic Surgery to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Wright Spellman Plastic Surgery and myself.

Signature _____ **Date** _____

(Revised 1/22)

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Name _____ Date _____

Thank you for choosing Wright Spellman Plastic Surgery. We offer a wide variety of services to help you achieve your goal of facial rejuvenation. To better serve you, please take a few moments to complete this questionnaire so that we may know your primary areas of concern and any procedures or services you may be interested in, now or in the future.

Please check all of the following areas which are of concern:

___ Acne scars
___ Brown spots
___ Double chin
___ Droopy brows
___ Flat cheeks
___ Uneven Texture
___ Jowls
___ Lines & wrinkles
___ Moles/skin lesions
___ Protruding ears
___ Puffy eyelids
___ Other
___ Sagging neck
___ Size & shape of nose
___ Thin & wrinkled lips
___ Weak chin
___ Clogged Pores

Services

The following is a list of services we provide. Please indicate which cosmetic procedures may be of interest to you.

___ Aesthetic/skin care services
___ Blepharoplasty (eyelid surgery)
___ Botox
___ Chemical Peel
___ Fuller lips
___ Rhinoplasty (Nasal surgery)
___ Facial laser resurfacing
___ Skin care products
___ Skin fillers
___ Otoplasty (corrective ear surgery)
___ Platysmaplasty (tightening of neck)
___ Forehead/browlift
___ Chin augmentation
___ Rhytidectomy (Face lift)
___ IPL (Intense Pulsed Light)

Do you currently have a skincare specialist? _____

Please indicate which time most closely fits your schedule if you decide to proceed with surgery:

___ ASAP ___ 1-3 months ___ 3-6 months ___ 6-12 months

*** A 10% deposit is required in order to hold a specific surgery date ***

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Patient History Form

Patient Name: _____ **Today's Date:**
DOB: _____/_____/_____ **Age:** _____
How did you first learn about Dr. Wright/Dr. Spellman _____
List reason(s) for today's visit and duration of problem(s): _____

Height: _____ **Weight:**_____ **Most Recent Blood Pressure:**_____
Who is your primary care physician? _____ **Tel: (_____) _____-_____**

Past Medical History:

Allergies to Medication: ☐No ☐Yes, (list medications): _____
Are you allergic to Latex? ☐No ☐Yes, (specify reaction): _____

List Current Prescription Medications (remember to include oral meds, nasal sprays/ steroids, and topical ointments):

1)_____ 4)_____ 7)_____ 10)_____
2)_____ 5)_____ 8)_____ 11)_____
3)_____ 6)_____ 9)_____ ☐ I have NO medications

Do you take blood thinners? ☐No ☐Yes, specify name and dosage: _____
Have you ever used Accutane? ☐No ☐Yes, When was your last dose? _____

List NON-prescription Meds: ☐ Aspirin____mg; ☐Advil/Motrin (ibuprofen); ☐Naproxen; ☐ Tylenol (acetaminophen);
☐Multivitamin; ☐ Vitamin E ☐ Other Vitamins_____; ☐Herbals (specify)_____;
☐ Other (specify) _____

Please check any medical problems you have had: ☐ I have none of the below listed conditions and no known illnesses.

☐ High blood pressure	☐ Diabetes	☐ Kidney failure	☐ Frequent infections
☐ Bleeding disorder	☐ Thyroid problems	☐ Lung problems	☐ Seizures/Epilepsy
☐ DVT/Blood clots	☐ Peptic or gastric ulcer	☐ Tuberculosis (TB)	☐ Depression
☐ Heart problems	☐ Reflux disease	☐ Cancer	☐ Bipolar disorder
☐ Stroke/TIA	☐ Hepatitis/HIV	☐ Radiation therapy	☐ Anxiety

☐ Other(s) not listed above (specify)
_____

Hospitalizations: (List problem(s) and year, not including surgeries) _____

Surgeries: (List operations and year performed including plastic surgeries) _____

Have you had LASIK surgery? ☐No ☐Yes, What was the procedure date? _____
Problems with general anesthesia? ☐No ☐Yes (specify reaction): _____

Radiology & Imaging: (List all CT scans or other imaging with dates) _____

Social History:

Tobacco use	☐Never	☐Cigs ☐Cigar ☐Pipe ☐Chew	_____packs/day for _____years
		☐Quit tobacco on ____/____/_____	
Alcohol use	☐Never	☐Wine ☐Beer ☐Shots ☐Mixed	_____drinks/day for _____years
Recreational drug use	☐Never	☐Cocaine ☐Marijuana ☐Pain med	☐ Other _____
Employment	☐None	☐Fulltime ☐Part time ☐Retired	Occupation _____

Marital status (optional)	☐Single	☐Married ☐Divorced / Separated	☐Widowed

Family History:	**Diseases:**	**Family Member(s)**
Serious Illnesses:	**Cancer:**	

SYSTEMS REVIEW:
Please check all applicable **symptoms** listed below. **Only check "None"** if no other boxes are checked in a particular category.

General Health (Constitutional): ☐ None
☐Unintentional weight loss ☐ Fever/Chills ☐ Fatigue

Eyes: ☐ None

Vision changes (decreased acuity, blurry, blindness)	☐ Both eyes	☐ Right eye	☐ Left eye
Double vision	☐ Both eyes	☐ Right eye	☐ Left eye
Eye pain	☐ Both eyes	☐ Right eye	☐ Left eye
Dry eyes	☐ Both eyes	☐ Right eye	☐ Left eye
Itching/burning/discharge	☐ Both eyes	☐ Right eye	☐ Left eye
Glaucoma	☐ Both eyes	☐ Right eye	☐ Left eye

Ears, Nose, Mouth, Throat: (problems other than reason for today's visit) ☐ None

☐ Hearing loss	☐ Nasal discharge or drainage	☐ Heartburn or reflux
☐ Itchy ears	☐ Nasal obstruction or blockage	☐ Difficulty swallowing
☐ Ear pain	☐ Sneezing	☐ Painful swallowing
☐ Ear discharge or drainage	☐ "Stuffy" nose or congestion	☐ Bleeding from throat
☐ Feeling of fluid in ears	☐ Snoring	☐ Difficulty chewing
☐ Ringing/Buzzing sound in ears	☐ Loss of sense of smell	☐ Dental, gum, or mouth pain
☐ Dizziness	☐ Seasonal/environmental allergy	☐ Voice changes
☐ Facial weakness	☐ Breathing difficulty	☐ Pronunciation difficulty
☐ Facial pain	☐ Nosebleeds (how many? _____)	☐ Mass or lump in throat or neck
☐ Migraine or tension headaches	☐ Mass or lump in nose	☐ Other:

Heart, Veins, Arteries (Cardiovascular): ☐ None

☐ Chest pain	☐ Leg pain with walking	☐ Congestive heart disease
☐ Irregular heartbeat	☐ Leg pain at rest	☐ Mitral valves prolapse
☐ Fainting or lightheaded spells	☐ Swelling or fluid in legs	☐ Other:

Lungs (Respiratory): ☐ None

☐ Shortness of breath	☐ Asthma or wheezing	☐ Pneumonia
☐ Coughing up blood	☐ Cough	☐ Other:

Stomach, Intestines (Gastrointestinal): ☐ None

☐ Nausea or vomiting	☐ Blood in stool	☐ Food intolerance
☐ Diarrhea or constipation	☐ Gastric/peptic ulcers	☐ Other: _____

Kidney, Bladder, Genitals (Genitourinary): ☐ None

☐ Blood in urine	☐ Difficulty passing urine	☐ Incontinence
☐ Painful urination	☐ Frequent urination	☐ Other: _____

Bones, Joints, Muscles (Musculoskeletal): ☐ None

☐ Muscle weakness/fatigue	☐ Joint stiffness/pain	☐ Osteoporosis
☐ Cramping	☐ Neck pain	☐ Other:

Skin (Integumentary): ☐ None

☐ Rash	☐ History of cold sores	☐ Jaundice
☐ Herpes	☐ Recent baldness	☐ Other:

Brain, Nerves (Neurological): ☐ None

☐ Paralysis	☐ Numbness or tingling	☐ Other:

Psychiatric: ☐ None

☐ Insomnia (trouble sleeping)	☐ Feeling anxious	☐ Eating disorders
☐ Feeling depressed	☐ Cutting/Self-inflicted injuries	☐ Other:

Hormones (Endocrine): ☐ None

☐ Heat/cold intolerance	☐ Excessive sweating	☐ Diabetes
☐ Thyroid disorder	☐ Excessive thirst/hunger/urination	☐ Other: _____

Blood (Hematologic/Lymphatic): ☐ None

☐ Problems with blood clots	☐ Bleeding too long (will not clot)	☐ Other:

For Women only: Are you pregnant? ☐ Yes ☐ No

STOP HERE. SECTION BELOW IS FOR DOCTOR USE

Physician Review with Patient:

_____ _____

Physician Signature Date

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HIPAA

To ensure compliance with the Federal HIPAA Regulations (2003),

I acknowledge that I have reviewed a copy of the Wright Spellman Plastic Surgery's Privacy Policy.

I have been given an opportunity to read this policy and to ask questions relative to the content.

Please specify what phone number you would like our staff to use when trying to contact you: _____

Please list person or persons we can speak to regarding your medical information:

1) _____

2) _____

Patient Signature DATE

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PATIENT FINANCIAL RESPONSIBILITY FORM

Patient Name: _____ Date: _____

The physicians of Wright Spellman Plastic Surgery require this form to be signed by our patients. We appreciate your cooperation. If you have any questions, please ask the receptionist.

1. **FINANCIAL RESPONSIBILITY**: We are pleased to assist with your insurance. I understand that with the exceptions explained below, I am personally responsible for any medical fees I will incur with Wright Spellman Plastic Surgery.
I also understand that I will be responsible for any charges incurred by not providing the most current, correct insurance to Wright Spellman Plastic Surgery.
Exceptions to this policy are those patients with a current authorization with an HMO, a State or Federally funded program, or a PPO in which Wright Spellman Plastic Surgery, is currently a contracted provider.

INSURANCE INFORMATION: As a Courtesy we will bill your primary and secondary insurance carrier if you provide ALL necessary information (such as insurance cards and/or completed and signed claim forms if your carrier requires it, and their correct billing address). All co-pays are collected for each visit at the time of service. It is ultimately my (patient's) responsibility to verify that the Physician which I am seeing is a contracted provider within my insurance network.

Signature of Patient or Legal Guardian: _____

2. **AUTHORIZTION TO RELEASE INFORMATION**: I hereby authorize Wright Spellman Plastic Surgery to release medical information acquired during my examination or treatment, to my insurance company, or other physicians required to participate in my care.

Signature of Patient or Legal Guardian: _____

3. **AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN**: I hereby authorize payment for medical services provided directly to the Wright Spellman Plastic Surgery physicians.

Signature of Insured or Patient: _____

4. **PLEASE READ AND THEN CHOOSE YES OR NO**:

If you are unavailable, may we leave medical information, such as normal blood test results or normal biopsy reports on your answering machine or with someone at your residence?

_____YES – you may leave information as above.
_____ NO – do not leave any information with anyone.

Signature of Patient or Legal Guardian: _____