# Patient Information

Dr. Caroline J. Plamondon M.D.
*Cosmetic & Reconstructive Plastic Surgery*

**Today's Date:** ________________

Welcome to our office. As a new patient, please fill out the information found below to the best of your ability. Please answer these health and beauty related questions to help us design the ideal experience for you. All information will remain confidential.

Patient Name / Responsible Party (if minor):____________________________________________

Mailing Address: ____________________________________________

City:______________________ State/Country:______________________ ZIP:______________

Telephone: Home______________________ Work______________________ Cell______________________

Date of Birth ___/____/______ Age_______________ Email Address:______________________

SS#: ______________________ Preferred Method of Contact: ___Home ___Cell ___ Work ___E-Mail

**Sex:** □Female □ Male **Marital Status:** □Single □Married □Widowed □Separated □Divorced

**How did you hear about Caroline J. Plamondon, MD?**
□Google □Facebook □RealSelf □Other/Define______________________ Referred by________________ □patient

The information provided above and during your scheduling may be used to contact you. Please do not provide information if it cannot be used.

Please check all of Dr. Plamondon's surgical and non-surgical procedures that interest you.

**FACE**
- □ Facelift, Neck Lift
- □ Eyelid Surgery
- □ Nose Surgery (cosmetic and breathing)
- □ Facial Contouring, Fat Grafting
- □ Prominent Ear, Otoplasty
- □ Other__________________

**BREAST**
- □ Breast Augmentation
- □ Breast Revision/Reconstruction
- □ Breast Lifts
- □ Breast Reduction
- □ Scar Revisions
- □ Nipple Surgery

**BODY**
- □ Tummy Tuck
- □ Liposuction
- □ Arm Lift (Brachioplasty)
- □ Other_________________
- □ Other_________________

**NON-SURGICAL**
- □ Botox Injections
- □ Dermal Fillers (e.g. Restylane, Juvederm)
- □ Microneedling with Radio Frequency
- □ Chemical Peels
- □ Anti-Aging, Prevention Skincare
- □ Sun Damage Repair
- □ Acne Treatments
- □ Scar Treatment
- □ PRP (Plasma Rich Protein) Therapy
- □ Other__________________________
- □ Other______________________
- □ Not sure, need consultation

PRIMARY CARE PHYSICIAN / PEDIATRICIAN

Name: ______________________ Phone: ______________________ Address: ______________________

Pharmacy: ______________________ Phone: ______________________ Address: ______________________

EMERGENCY CONTACT

Name: ______________________ Phone: ______________________ Relationship: ______________________

INSURANCE

Plan Name: ______________________ Primary Insurer: ______________________ Subscriber ID: ______________________

Group#: ______________________ Secondary Insurance: ______________________

Assignment and Release (Insurance Patients Only)
I, the undersigned, have insurance coverage with the company named above. I assign, directly to Dr. Plamondon, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, including possible hospitalizations, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

Patient Signature:______________________ Date: _________

Dr. Caroline J. Plamondon M.D.
*Cosmetic & Reconstructive Plastic Surgery*

Patient Name:______________________________ Today's date:__________

Age:__________ Birthdate:____________ Date of last physical examination:________________

## Symptoms

Check (✓) symptoms you currently have or have had in the past year.

### General
- ☐ Chills
- ☐ Depression/Anxiety
- ☐ Eating Disorder *(Bulimia, Anorexia)*
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

### Muscle/Joint/Bone
Pain, weakness, numbness:
- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

### Gastrointestinal
- ☐ Poor appetite
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Reflux
- ☐ Stomach pain
- ☐ Ulcers
- ☐ Vomiting
- ☐ Vomiting blood

### Genito-Urinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

### Eye, Ear, Nose, Throat
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

### Women
Are you pregnant? ____
Number of children ____

### Cardiovascular
- ☐ Chest pain/Heart attack
- ☐ Heart murmur or leaking valve
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood sugar
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

### Skin
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

## Conditions

Check (✓) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Blood clot
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Drug or Alcohol dependency
- ☐ Diabetes
- ☐ Emphysema
- ☐ Embolism
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis B or C
- ☐ Hernia
- ☐ High cholesterol
- ☐ HIV Positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraine headaches
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers

- ☐ Psychiatric Care

If yes, Doctor's Name
____________________

## Medications

List **all** medications you are currently taking.

______________________________
______________________________
______________________________
______________________________

## Allergies

______________________________
______________________________
______________________________
______________________________

## Past Surgeries

| Year | Hospital | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Past Hospitalization for Serious Illnesses

| Year | Hospital | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates: ____________________________________________

## Health Habits

Check (✓) which substances you use and describe how much you use.

| | | |
|---|---|---|
| | Caffeine | |
| | Tobacco | |
| | Drugs | |
| | Other | |

## Occupational

Check (✓) if your work exposes you to the following:

| | |
|---|---|
| Stress ☐ | Hazardous Substances ☐ |
| Heavy Lifting ☐ | Other ☐ |

**Occupation**

## Family Health

Check If, your blood relatives had any of the following:

| ✓ | Disease | Relationship to you |
|---|---|---|
| | Arthritis, Gout | |
| | Asthma, Hay Fever | |
| | Cancer | |
| | Chemical Dependency | |
| | Diabetes | |
| | Heart Disease, Strokes | |
| | High Blood Pressure | |
| | Kidney Disease | |
| | Tuberculosis | |
| | Other | |

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:____________________________________________ Date: ____________________

Caroline J. Plamondon M.D.
*Cosmetic & Reconstructive Plastic Surgery*

## INSURANCE WAIVER OF LIABILITY

Insurance regulations require that I inform you that your insurance company may possibly deny coverage for surgical procedures that have been requested by you or recommended to you by myself or other health care providers.

Most insurance companies' will either not pre-authorize surgery and/or may retroactively deny it. If this occurs, it is the policy of this office to bill you directly after appealing to your insurance company for you. It is recommended that you also appeal directly if your insurance company denies you coverage.
If your insurance company ultimately denies covering your surgery, you will be responsible for the surgical fee up to the reimbursement level normally provided by your insurance company.

**Initial: ________**

## INSURANCE DEDUCTIBLE FOR SURGICAL PATIENTS

In the event you become a surgical patient, we require **a copy of the front and back of your credit/debit card** to cover any deductible that your insurance plan may indicate. Our office will verify this amount of ahead of time through your insurance carrier. We will submit the claim to your insurance carrier on your behalf.

If after the first billing cycle payment has not been received or arrangements have not been agreed upon, any outstanding deductible will be charged to the credit card you have provided us. A 2.5% convenience fee will be assessed to any charge over $100. You may also choose to write us a check which we will hold until we receive notification of payment from your insurance company. By signing below, I acknowledge that I have read and agree to the above policies.

**Signature:________________________________________**

## PRIVACY AND CONFIDENTIALITY NOTICE

We understand that many patients are concerned about the privacy surrounding their decision to have plastic surgery. This notice describes how the personal and medical information you provide may be used. Please review it carefully and sign below. If you have any questions, please do not hesitate to speak with our office staff.

Dr. Plamondon and her staff believe your personal and medical information should remain confidential. Your decision to enhance your look is a personal one and it is our pledge that we will safeguard the information you provide to the best of our abilities. Our efforts to safeguard your personal and medical information include training our staff on the principals and importance of patient confidentiality, keeping patient charts and photographs safe and secure, and transmitting only necessary information to facilities such as the hospital and anesthesiologist.

I have read and understand the Privacy and Confidentiality Notice and all questions have been answered to my satisfaction. I understand I may have a copy of the Privacy and Confidentiality Notice if I wish.

**Initial: ________**

## CONSENT TO TAKE PHOTOGRAPS

I hereby authorize Caroline J. Plamondon, M.D. and her associates or licensees to take pre-operative and post- operative Photographs.

I understand that such photographs shall become the property of Dr. Plamondon and will be retained by Dr. Plamondon. I UNDERSTAND THAT TREATMENT WILL NOT BE GIVEN IF PRE-OPERATIVE AND POST-OPERATIVE PHOTOGRAPHS ARE NOT TAKEN AS THESE ARE A PART OF EVERY MEDICAL EXAMINATION AND A CRITICAL PART OF MY PATIENT CHART.

I also authorize Caroline J. Plamondon, M.D. to use these photographs for the purpose of teaching, as a tool to inform other patients, or as part of Dr. Plamondon's internet website. Photographs will always be used in an anonymous fashion. Body photographs never show the face; however, if the surgery involves part or the whole face, I still authorize Caroline J. Plamondon, M.D. to use the photographs as mentioned above. Please choose one of the following:

**Restrictions: Medical Chart only: ______**
**No face photos on the internet: ___**
**All identifiable tattoos, piercings, etc; to be cropped out before internet use: ______**
**NO Restrictions to use of photographs: _____**

**I have read and understand the above policies.**
Patient Signature: ____________________________________
Print Name: __________________________________________
Date:_______________________________________________

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