

PLASTIC SURGERY CLINIC  
OF EAU CLAIRE

Ember Ewings, MD

PATIENT INFORMATION

This record will become part of your permanent file.

Please write legibly and complete both sides.

EMAIL (REQUIRED)

☐

☐

☐

M

F

Other

NAME: FIRST

MIDDLE

LAST

DATE OF BIRTH

AGE

ETHNICITY

ADDRESS

CITY

STATE

ZIP

HOME PH.

CELL PH.

☐ SINGLE

☐ MARRIED

☐ WIDOWED

☐ DIVORCED

☐ FULL TIME STUDENT

EMPLOYER/ AND OR SCHOOL

Occupation

NAME OF SPOUSE / PARENT (IF UNDER 18):

SPOUSE / PARENT'S EMPLOYER NAME & ADDRESS

PHONE

FAMILY DOCTOR: NAME & ADDRESS

PHONE

Pharmacy Name/Location

PHONE

OR REFERRED BY (PLEASE SPECIFY):

☐ FRIEND

☐ Billboard

☐ WEBSITE

☐ OTHER

☐

PRIMARY INSURANCE NAME

SUBSCRIBER NAME

SUBSCRIBER DOB

SUBSCRIBER SS#

SUBSCRIBER NO.

GROUP NO.

GROUP NAME

I acknowledge that I have received written Notice of Privacy Practices from Plastic Surgery Clinic of Eau Claire.

I authorize release of any medical information which may be requested by my insurance company concerning my present illness or injury. I authorize payment of any medical benefits to which I am entitled for services provided by Plastic Surgery Clinic of Eau Claire. I understand that I am financially responsible for any charges not paid by my insurance company. I understand no claims will be filed with my insurance carrier/Medicare/Medicaid for cosmetic procedures and that I am responsible for any costs associated with consultation or surgery.

☐ THE PATIENT'S CONDITION PROHIBITS THE INDIVIDUAL FROM SIGNING AN ACKNOWLEDGEMENT AT THIS TIME. IT WILL BE OBTAINED AS REASONABLY PRACTICABLE AFTER THE PATIENT'S CONDITION IMPROVES.

☐ ACKNOWLEDGEMENT WAS UNABLE TO BE OBTAINED. REASON \_\_\_\_\_

PATIENT OR PERSONAL REPRESENTATIVE

DATE

NAME: FIRSTMIDDLELASTEmail

PERSONAL HISTORY:

YESNO

TUBERCULOSIS

DIABETES

HEART CONDITION

STROKE

ANEMIA

CANCER

EPILEPSY

NERVOUS DISORDER

ASTHMA / HAY FEVER

PACEMAKER / ICD

IMPLANTS

INFECTIONS

BLEEDING HISTORY

HEPATITIS

BLOOD PRESSURE

HIGH

LOW

NORMAL

OTHER DISEASES

PERSONAL OR FAMILY HISTORY

YESNO

MALIGNANT HYPERTHERMIA

UNEXPECTED DEATH

SINUSITIS

NEUROMUSCULAR DISORDER

UNANTICIPATED FEVER FOLLOWING  
GENERAL ANESTHESIA

ALLERGIES & SENSITIVITIES:

YESNO

PENICILLIN

SULFA DRUGS

OTHER ANTIBIOTICS

ASPIRIN

CODEINE

PERCOCET

VICODIN

ANESTHETICS

ADHESIVE TAPES

LATEX

FOODS

REMARKS

PREVIOUS SURGERIES AND DATES:

HAVE YOU HAD ANY COSMETIC SURGERY?

YESNO

IF YES, PLEASE SPECIFY:

NO. OF PREGNANCIES:

NO. OF CHILDREN:

LAST MENSTRUAL PERIOD:

CURRENT MEDICATIONS AND VITAMINS:

LAST PHYSICAL CHECKUP:

HEIGHT

WEIGHT

GENERAL HEALTH:

DO YOU TAKE COUMADIN/WARFARIN/PLAVIX?

YESNO

DO YOU USE TOBACCO/

VAPE/E-CIGARRETES

YES, HOW MUCH:

NO

CONSUME ALCOHOL?

YES, HOW MUCH:

NO

Occupation

Hobbies

NAME: FIRSTMIDDLELASTEMAIL (REQUIRED)

BREAST SURGERY

- ☐ BREAST AUGMENTATION (ENLARGEMENT)
- ☐ MASTOPEXY (BREAST LIFT)
- ☐ BREAST REDUCTION (FEMALE)
- ☐ BREAST IMPLANT EXCHANGE/REMOVAL
- ☐ GYNECOMASTIA (MALE BREAST REDUCTION)
- ☐ POST-MASTECTOMY RECONSTRUCTION
- ☐ TREATMENT OF BREAST ASYMMETRY
- ☐ TREATMENT OF INVERTED NIPPLE

FACIAL COSMETIC SURGERY

- ☐ FACE LIFT/CHEEK & NECK LIFT
- ☐ BROW LIFT
- ☐ UPPER EYELID BLEPHAROPLASTY
- ☐ LOWER EYELID BLEPHAROPLASTY
- ☐ CHIN ENHANCEMENT
- ☐ CHEEK ENHANCEMENT
- ☐ FAT INJECTIONS (FOR LACK OF FACIAL VOLUME)

NASAL SURGERY

- ☐ RHINOPLASTY (COSMETIC NASAL SURGERY)
- ☐ NASAL TIP IMPROVEMENT

COSMETIC EAR SURGERY

- ☐ OTOPLASTY (EAR PINNING)
- ☐ EAR LOBE REDUCTION
- ☐ REPAIR TORN EARLOBE

SURGICAL BODY CONTOURING

- ☐ ABDOMINOPLASTY (TUMMY TUCK)
- ☐ THIGH LIFT
- ☐ MOMMY MAKEOVER
- ☐ SKIN REMOVAL AFTER MAJOR WEIGHT LOSS
- ☐ BRACHIOPLASTY (UPPER ARM LIFT)
- ☐ BUTTOCK LIFT
- ☐ SUCTION-ASSISTED LIPECTOMY (LIPOSUCTION):
  - ☐ ABDOMEN
  - ☐ THIGHS
  - ☐ NECK/CHIN
  - ☐ KNEES
  - ☐ ARMS
  - ☐ HIPS

NON-SURGICAL BODY CONTOURING

- VIOIRA REACTION**
  - ☐ CELLULITE REDUCTION
  - ☐ SKIN TIGHTENING
  - ☐ CIRCUMFERENTIAL REDUCTION (ARMS, THIGHS, TUMMY)
  - ☐ NECK/JOWLS/CHIN TIGHTENING

PELLEVÉ WRINKLE REDUCTION SYSTEM

- ☐ FACIAL WRINKLE REDUCTION
- ☐ TREATMENT OF LINES AROUND MOUTH OR NASOLABIAL FOLDS
- ☐ TREATMENT OF EYE AREA

FACIAL REJUVENATION

- CLINICAL TREATMENTS**
  - ☐ LASER RESURFACING
  - ☐ MICROLASER PEEL /PROFRACTIONAL LASER
  - ☐ BOTOX®/DYSPORT®
  - ☐ DERMAL FILLERS
- SPA TREATMENTS**
  - ☐ MICRODERMABRASION
  - ☐ CHEMICAL PEELS
  - ☐ CLINICAL FACIALS
  - ☐ BROADBAND LIGHT (PHOTO FACIALS)
  - ☐ HALO HYBRID FRACTIONAL LASER
  - ☐ LASER HAIR REDUCTION
  - ☐ HAIR REDUCTION (WAXING)
  - ☐ ACNE TREATMENTS
  - ☐ LATISSE® (FOR THICKER, DARKER, LONGER LASHES)
  - ☐ ENZA ESSENTIALS CUSTOMIZED SKIN CARE

OTHER

- VAGINAL REJUVENATION - DO YOU HAVE CONCERNS WITH:**
  - ☐ VAGINAL DRYNESS OR LAXITY
  - ☐ PAIN DURING INTERCOURSE
  - ☐ INCONTINENCE OR BLADDER CONTROL

OTHER: SKIN & BODY

- ☐ SCAR IMPROVEMENT
- ☐ MOLE, LESION, OR SKIN CANCER TREATMENT
- ☐ LASER NAIL FUNGUS TREATMENT
- ☐ HAND REJUVENATION
- ☐ OTHER : \_\_\_\_\_

PLEASE TELL US HOW YOU FIRST HEARD ABOUT US

- ☐ FRIEND
- ☐ RADIO
- ☐ INTERNET
- ☐ BILLBOARD
- ☐ TELEVISION
- ☐ PRINT AD
- ☐ DOCTOR REFERRAL
- ☐ SEMINAR
- ☐ OTHER: \_\_\_\_\_

WHAT PROMPTED YOU TO MAKE THIS APPOINTMENT?