

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: FIRST _____ MIDDLE _____ LAST _____ Email _____

PERSONAL HISTORY:	YES	NO	REMARKS
TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	_____
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART CONDITION	<input type="checkbox"/>	<input type="checkbox"/>	_____
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	_____
ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	_____
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	_____
EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>	_____
NERVOUS DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	_____
ASTHMA / HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>	_____
PACEMAKER / ICD	<input type="checkbox"/>	<input type="checkbox"/>	_____
IMPLANTS	<input type="checkbox"/>	<input type="checkbox"/>	_____
INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>	_____
BLEEDING HISTORY	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	_____
BLOOD PRESSURE	HIGH <input type="checkbox"/>	LOW <input type="checkbox"/>	NORMAL <input type="checkbox"/>
OTHER DISEASES	_____		

PERSONAL OR FAMILY HISTORY	YES	NO
MALIGNANT HYPERTHERMIA	<input type="checkbox"/>	<input type="checkbox"/>
UNEXPECTED DEATH	<input type="checkbox"/>	<input type="checkbox"/>
SINUSITIS	<input type="checkbox"/>	<input type="checkbox"/>
NEUROMUSCULAR DISORDER	<input type="checkbox"/>	<input type="checkbox"/>
UNANTICIPATED FEVER FOLLOWING GENERAL ANESTHESIA	<input type="checkbox"/>	<input type="checkbox"/>

ALLERGIES & SENSITIVITIES:	YES	NO	REMARKS
PENICILLIN	<input type="checkbox"/>	<input type="checkbox"/>	_____
SULFA DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER ANTIBIOTICS	<input type="checkbox"/>	<input type="checkbox"/>	_____
ASPIRIN	<input type="checkbox"/>	<input type="checkbox"/>	_____
CODEINE	<input type="checkbox"/>	<input type="checkbox"/>	_____
PERCOCET	<input type="checkbox"/>	<input type="checkbox"/>	_____
VICODIN	<input type="checkbox"/>	<input type="checkbox"/>	_____
ANESTHETICS	<input type="checkbox"/>	<input type="checkbox"/>	_____
ADHESIVE TAPES	<input type="checkbox"/>	<input type="checkbox"/>	_____
LATEX	<input type="checkbox"/>	<input type="checkbox"/>	_____
FOODS	_____		

PREVIOUS SURGERIES AND DATES: _____

HAVE YOU HAD ANY COSMETIC SURGERY? YES NO
 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? YES NO

DO YOU USE TOBACCO/

VAPE/E-CIGARRETES YES, HOW MUCH: _____ NO

CONSUME ALCOHOL? YES, HOW MUCH: _____ NO

Occupation

Hobbies

NAME: FIRST

MIDDLE

LAST

EMAIL (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

VIORA 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
- INTERNET
- TELEVISION
- DOCTOR REFERRAL
- OTHER: _____
- RADIO
- BILLBOARD
- PRINT AD
- SEMINAR

WHAT PROMPTED YOU TO MAKE THIS APPOINTMENT?
