Desert Plastic Surgery

John M. Pierce, M.D.

Name:_____ Age:_____ Date of Birth:_____
Last First Middle

How would you like to be addressed?:_____ Preferred pronoun:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Email:_____ Preferred Contact: email / text / call

Gender: Male / Female Marital Status: Married / Single / Widowed / Divorced / Separated

Occupation:_____ Employer:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Who referred you or how did you hear about us? _____

Primary Care Doctor:_____

What is the reason for this visit? _____

Have you seen any other plastic surgeons for this issue? Yes / No

If so, who did you see? _____

List any other surgeries/services you are interested in _____

_____

Assignment and Release: I hereby assign all major medical and/or surgical insurance benefits to which I am entitled, including Medicare, private insurance, or any other health plan, to Desert Plastic Surgery, PC/John M. Pierce, M.D. I understand that I am financially responsible for all charges, whether paid by said insurance, unless assignee has an executed agreement with my insurance plan or provider, indicating otherwise. I understand if such and agreement exists, I am responsible for payment of any deductibles and/or co-payments required under the terms of my insurance plan. Should collection procedures become necessary, I agree to pay all costs associated with the collection of this debt, including but not limited to attorney's fees and court costs. I hereby authorize assignee to release any and all information obtained in the course of my examination and treatment to secure payment of insurance benefits. A photocopy of this assignment shall be considered as valid as it's original.

Signature: _____ Date: _____

Desert Plastic Surgery

John M. Pierce, M.D.

Medical History

Name: _____ Date: _____
Last First Middle

Past Medical History (check all that apply):

☐ None ☐ Problems with Anesthesia (General or local) ☐ Heart Disease or Murmur ☐ Pacemaker ☐ Hypertension ☐ Stroke/Seizures ☐ Asthma/COPD/ Emphysema	☐ Autoimmune Disease ☐ Abnormal Scarring ☐ Abnormal Healing ☐ Skin Disorders/Rashes ☐ Thyroid Disorder ☐ Bleeding/Clotting Disorder ☐ DVT/Pulmonary Embolism ☐ Diabetes ☐ HIV/AIDS	☐ Kidney Disease ☐ Hepatitis/Liver Disease ☐ Gastrointestinal Disease/Gerd/Ulcers ☐ History of DVT or Pulmonary Embolism ☐ Mental Health Issues ☐ Cancer ☐ Depression/Anxiety ☐ Arthritis	☐ Other Medical Conditions Not Listed: _____ _____ _____ _____ _____ _____ _____

Past Surgeries (please list all past surgical procedures):

Surgery	Date	Type of Anesthesia
		Local / General / Unknown
		Local / General / Unknown
		Local / General / Unknown
		Local / General / Unknown
		Local / General / Unknown

Family Medical History:

☐ Cancer ☐ Heart Disease ☐ Breast Cancer Relation: _____ ☐ Stroke ☐ Diabetes	☐ Malignant Hypertension ☐ Clotting Disorder ☐ Problems with Anesthesia ☐ Other: _____

Name: _____
Last First Middle

Please list all medications and supplements you are currently taking:

Prescription Medications	Over The Counter/Supplements

Are you allergic to any medications?

- ☐ No known medication allergies
- ☐ I am allergic to the following medications:

Medication	Reaction

Latex Allergy: Yes / No

Non-Medication Allergies: _____

Do you smoke, chew or vape tobacco	☐ No	☐ Yes	☐ Former	Date Stopped:
Do you use alcohol	☐ No	☐ Yes	☐ Social	Drinks per day:
Do you use marijuana	☐ No	☐ Yes		Frequency:
Do you use illegal drugs	☐ No	☐ Yes	☐ Former	Drug:

Height: ____ feet ____ Inches Weight: _____ lbs

Pharmacy Name & Location_____ Pharmacy Phone_____

Female Patients Only:

Do you have children? Yes / No If yes, how many? _____ Problems with Pregnancy:_____

Have you had a recent mammogram? Yes / No If yes, were any abnormalities found? _____

Do you have any family history of breast cancer? Yes / No If yes, which relative? _____