

Patrick H. Pownell, M.D., P.A.
PLASTIC AND RECONSTRUCTIVE SURGERY

HEALTH INFORMATION

Patient Name: _____ Date: _____

Purpose of appointment with Dr. Pownell: _____

Medical History

Do you now have or have you ever had any of the following:

	YES	NO		YES	NO		YES	NO
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Eye Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmurs	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Depression	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Chronic lung or bronchial disease	<input type="checkbox"/>	<input type="checkbox"/>
Any Other Serious Illness	<input type="checkbox"/>	<input type="checkbox"/>				Trouble with dryness, soreness, burning, itching or excessive tearing of eyes	<input type="checkbox"/>	<input type="checkbox"/>

Hospitalizations and/or previous surgeries: Please list with dates: _____

Allergies

Are you allergic to, or have you ever had a reaction to any medication, drug or local anesthetic? Yes No
 If Yes, please list: _____

Medications

Please list any medication you currently take on a regular basis (aspirin, ibuprofen, birth control pills, herbals, and vitamins included).

Please list any medications taken on a regular basis in the past five (5) years.

Bleeding/Scarring/Anesthesia

	YES	NO
Do you or a member of your family have difficulty with prolonged bleeding when cut?	<input type="checkbox"/>	<input type="checkbox"/>
Do you or a member of your family bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a problem with excessive scarring or have you ever formed a keloid after being cut?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or any member of your family ever had a problem with anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any of the above, please explain: _____

Personal History

How would you describe your general health? Excellent Good Fair Poor
 Do you smoke? Yes No _____/per day Have you smoked in the last 5 years? Yes No

Do any diseases run in your family? _____

Date of last physical examination? _____

Primary Care Physician: _____

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MEDICAL INSURANCE INFORMATION

Patients should sign in both signature blanks at the bottom of this page.

PRIMARY INSURANCE

Name of Primary Insurance Company: _____

Address and Phone Number of this Company: _____

Name of Insured: _____

Address (if different from patient): _____

Insured's Employer: _____

Insured's SSN: _____ Insured's Date of Birth: _____

Group/Policy #: _____ ID#: _____

SECONDARY INSURANCE

Do you have additional Insurance coverage? _____ Yes _____ No

Name of Secondary Insurance Company: _____

Address and Phone Number of this Company: _____

Name of Insured: _____

Insured's Employer: _____

Insured's SSN: _____ ID#: _____

Group/Policy#: _____ ID#: _____

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the undersigned physician or supplier for services described.

Signed (Insured/Authorized Person) Date

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process claims and/or predetermination letters.

Signed (Patient, or parent if minor) Date

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In the course of treatment with Dr. Pownell, you may be referred to, or certain surgical services may be performed at, Texas Institute for Surgery at Presbyterian Hospital of Dallas. Dr. Pownell has an ownership interest in this hospital, and as a result, he may financially benefit from the referral of services to the hospital in the form of increased dividends or distributions. You have the option of using an alternative health care facility. *Please let us know if you have any concern regarding the financial relationship between Dr. Pownell and Texas Institute for Surgery at Presbyterian Hospital of Dallas.*

**Acknowledgement of Review of
“Notice of Privacy Practices Form”**

I have reviewed the Notice of Privacy Practices for this office which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative’s Authority

E-Mail Policy

To better serve our patients, this office has established an e-mail address for some forms of communication.

Forms of communication that are appropriate include:

Scheduling Inquiries
Insurance Questions
Educational Materials

Please note, any and all healthcare questions should be addressed via phone communication
Or physician visit.

Signature of Patient or Personal Representative

Date