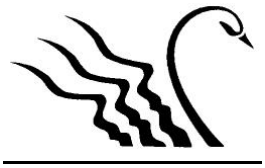

CENTER FOR COSMETIC SURGERY AND MEDICAL SPA
540 MADISON OAK DRIVE, SUITE 400 * SAN ANTONIO, TEXAS 78258 * 210.545.4848 *
www.eharrismd.com

(Please print in black ink only)

Patient's Name: _____
First Middle Last
SSN: _____ DOB: _____/_____/_____ Age: _____

Gender: male female Marital Status: married single □divorced □other

Address: _____

City: _____ State _____ Zip Code _____

Home ph: (___) _____ Work ph: (___) _____ Cell ph: (____) _____

What is the best number to contact you: _____

Email address: _____

What is your preferred contact method: phone email fax mail other: _____

How did you hear about us?

Internet: website Google Yahoo MSN City Search Realself other: _____

Media: phone book magazine newsletter seminar other:_____

Were you referred to us by anybody: no / yes – doctor friend/family member

Name of person who referred you: _____

If you were referred by a specific person, may we thank them? □ Yes □ No

Employer: _____ Occupation: _____

Emergency contact: _____Relationship: _____

Home ph: (___) _____ Work ph: (___) _____ Cell ph: (____) _____

Responsible party: _____ Relationship to patient: _____

Reason for visit: _____

In case of emergency, may we notify this contact? Yes / No
What is your preferred language? English Spanish
other:_____

What is your ethnicity? (Optional) African American / Asian / Caucasian / Hispanic / Indian / Native American

Other:_____

What is your preferred local pharmacy? _____phone: (____)_____

I attest the above to be true and accurate to the best of my knowledge.
I understand that I am responsible for all fees for any and all services purchased and provided by The Center for Cosmetic Surgery and Medical Spa.
All charges are due and payable the date they are incurred.
I understand that there will be no refunds on any services performed, pre-paid packages purchased and/or skin care products purchased.
I understand that skin care products bought and/or samples given are intended for me and my skin type only and should not be shared with any other individuals. _____ (please initial)

Signature: _____ Date: _____

MEDICAL HISTORY

Patient Name:
_____**Height**_____**Weight**_____

Prior Surgery and/or hospitalization for any reason including childbirth

YEAR	

Current Medications (Medications, vitamins and supplements) with dosage:

MEDICATION	WHAT DO YOU TAKE IT FOR	DOSAGE

MEDICINE ALLERGIES: _____

Have you ever taken Accutane: yes no **Have you ever had cold sores, fever blisters or mouth ulcers:** yes no

Tobacco History: Cigarettes / Cigar / Pipe / Chew **How Many Years?** _____ **Packs/day**_____
Quit: yes/no **Date:** _____

Have you ever had:
Restylane Collagen Botox Hylaform Radiesse Juvederm Other: _____

Have you ever had a problem or reaction with any of the following?
Local anesthetics Adhesive tape Antibiotics Pain killers Iodine Latex other_____

Have you ever had:
A REACTION TO ANESTHESIA yes/no
ABNORMAL BLEEDING yes/no
BLOOD TRANSFUSION yes/no
Are you taking any appetite suppressants or herbal supplements? yes/no
Have you or a family member ever had difficulty with GENERAL ANESTHESIA? yes/no

Have you ever taken:
BLOOD THINNERS yes/no
STEROIDS yes/no
HIGH BLOOD PRESSURE MEDICATION yes/no

Do you now or have you ever had: (Please circle all that apply)

ABNORMAL SCARS
AIDS/ HIV
ANGINA
ARTHRITIS
ASTHMA
AUTOIMMUNE DISEASE
ANXIETY/PANIC ATTACKS
BLACK STOOLS
BLOOD IN URINE
CANCER
CHEST PAIN
DEEP VEIN THROMBOSIS
DIABETES
EMPHYSEMA
EPILEPSY
HEART TROUBLE
HEPATITIS
HIGH BLOOD PRESSURE
JAUNDICE
KIDNEY/BLADDER DISEASE
LIVER DISEASE
NERVOUS BREAKDOWN
PAIN/NUMBNESS HANDS/FEET
PSYCHIATRIC CARE
PULMONARY EMBOLUS
RHEUMATIC FEVER
SKIN CONDITION
SLEEP APNEA
STROKE
TUBERCULOSIS

Have any other health issues? _____
Have you had recent dental work? _____
Have you ever had problems with scars? _____

Name of family doctor: _____ **date of last check up:** _____

FOR WOMEN

Any abnormalities on breast _____ **Have you ever had a mammogram?** yes no

Date of last mammogram _____**Where:** _____

Have you had a hysterectomy? yes no
Have you had a tubal ligation? yes no

Children: NO YES **Number of children** _____

Are you pregnant? yes no

Do you have breast implants? yes no _____

Family history of breast cancer? yes no if yes, Who _____

NOTICE OF HIPAA COMPLIANCE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. I have certain rights to privacy regarding my protected health information. I understand that this information can and only will be used to:

1. Conduct, plan and direct my treatment and follow- up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
2. Obtain payment from third-party payers
3. Conduct normal healthcare operations such as quality assessments and physician certifications, medical photography and development, surgery scheduling, and transcription of medical records as well as other such related procedures

Please initial the following statements that apply:

_____ Dr. Elizabeth S. Harris and/or staff have my permission to leave messages regarding my medical and/or financial condition on my answering machine.

_____ Dr. Elizabeth S. Harris and/or staff do not have my permission to leave messages regarding my medical and/or financial condition on my answering machine.

_____Dr. Elizabeth S. Harris and/or staff has my permission to correspond via email

I understand that more detailed information is available to me if needed.

Print Name: _____

Relationship to Patient: _____
(if a minor)

Signature: _____

Date: _____

Please list below individuals to whom we may release ANY medical information

Date	Disclose to Whom	Phone Number	Relationship