PATIENT REGISTRATION

Leland H. Webb, M.D. Plastic Surgery, PLC

5410 N Scottsdale Rd C-100, Paradise Valley, AZ 85253

Please Fill Out Completely and Print Clearly

Acct # _____
☐ New Patient

Today's Date _____ Appointment Date _____
Patient Name _____
Birthdate _____ Age _____ **Sex:** Female _____ Male _____
Social Security Number _____ **Primary Language:** _____
Ethnicity: Hispanic or Latino * Non-Hispanic or Latino (circle one)
Race: (circle one)
American Indian/Native Alaskan * Asian * African/African American * Caucasian * Native Hawaiian/Pacific Islander
Patient Address _____City_____ State_____ Zip_____
Home Phone _____ **Work Phone**_____
Mobile Phone_____ **Email** _____
Preferred pharmacy name and telephone number_____
Is it okay to leave messages containing medical information on voicemail? If yes, indicate authorized phone numbers:
__Home __Cell __Work __Other_____

Employer _____**Occupation** _____
Marital Status _____ **Spouse Name** _____

Do you have an Advance Directive? _____. If yes, please provide our office with a copy for your medical record.
In the event you are unable to make decisions for yourself, who do you authorize to make decisions on your behalf?

_____
Name/Relationship Phone Number

If Patient Is a Minor

Responsible Party _____

Mother's Name _____	Father's Name _____
Address (if different from above)	Address (if different from above)
_____	_____
_____	_____
Home Phone _____	Home Phone _____
Work Phone _____	Work Phone _____
Mobile Phone _____	Mobile Phone _____
SSN _____	SSN _____
DOB _____	DOB _____

Reason for Visit _____
How Did You Hear About Us? _____

Primary Care Physician	**Referring Physician**
Name _____	Name _____
Address _____	Address _____
City _____St _____ Zip _____	City _____St _____ Zip _____
Phone _____	Phone _____
Specialty _____	Specialty _____

Other Physicians/Doctors	**Specialty**	**Phone**
_____		
_____		
_____		
_____		

PATIENT INSURANCE INFORMATION
Leland H. Webb, M.D. Plastic Surgery, PLC
5410 N Scottsdale Rd C-100, Paradise Valley, AZ 85253
Please Fill Out Completely and Print Clearly

Patient Name _____ Date of birth_____ Date _____

Primary Insurance

Insurance Co. Name _____
Insurance Co. Address _____
Policy Holder's Name _____
Relationship to Patient ___self ___spouse ___child ___other_____
Employer _____
Policy # _____
Group # _____
Policy Holder's SSN _____
Policy Holder's Birth date _____

I confirm the above patient named has no other insurance coverage

_____ _____
Signature of Patient/Responsible Party Date

Secondary Insurance

Insurance Co. Name _____
Insurance Co. Address _____
Policy Holder's Name _____
Relationship to Patient ___self ___spouse ___child ___other_____
Employer _____
Policy # _____
Group # _____
Policy Holder's SSN _____
Policy Holder's Birth date _____

****ALL PATIENTS OR RESPONSIBLE PARTIES MUST SIGN BELOW REGARDLESS OF INSURANCE STATUS OR SELF PAY SITUATIONS**

I hereby authorize pre and post-operative photographs to be taken of me for medical records and insurance claim purposes.
____ I authorize ____ I do not authorize the use of my photographs for educational purposes.
I agree that this office may release medical records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. Disclosure of ownership: none.

I hereby assign all major medical and/or surgical insurance benefits to which I am entitled, including private insurance, Medicare and any other health plan or insurance benefits, to the provider indicated above. I understand that I am financially responsible for all charges whether or not paid by said insurance, unless assignee has executed an agreement with my insurance provider or plan. I understand that if such an agreement has been executed, I am responsible to pay any deductible and/or co-payment required under the terms of my insurance plan. Should collection procedures become necessary, I agree to pay the collection agency's cost and/or reasonable attorney's fees.

A photocopy of this assignment/authorization is to be considered as valid as the original.

_____ _____
Signature of Patient or Responsible Party **Date**

WEBB PLASTIC SURGERY

Today's date: _____

FILL OUT COMPLETELY. WE MUST HAVE YOUR COMPLETE MEDICAL HISTORY AND MEDICATION LIST IN ORDER TO SCHEDULE YOUR SURGERY AND OBTAIN ANY NECESSARY CLEARANCES PRIOR TO SURGERY. IF YOU DO NOT HAVE YOUR COMPLETE MEDICAL HISTORY AND MEDICATION LIST WITH YOU PLEASE INFORM OUR PROVIDER DURING YOUR APPOINTMENT.

Patient Name _____ DOB _____ Height _____ Weight _____ BMI _____

CHECK YES OR NO TO ALL MEDICAL CONDITIONS BELOW

No	Yes		No	Yes	
		Asthma			Hypothyroidism
		Allergies			Diabetes
		COPD			Obesity
		Sleep apnea, do you use CPAP?			Osteoarthritis
		Hypertension			Rheumatoid arthritis
		Coronary artery disease			Gout
		Congestive heart failure			Fibromyalgia
		History of heart attack, when			Anxiety
		Pacemaker/defibrillator			Depression
		Atrial fibrillation			PTSD
		History of pulmonary embolism, when			Attempted suicide
		History of DVT, when			Anorexia/bulimia
		Stroke, when			Dementia
		Edema (swelling)			Delayed wound healing
		Varicose veins			Keloids
		Anemia			Cellulitis
		Hemophilia			Sepsis
		High Cholesterol Hypercholesterolemia			History of unexplained stillborn infant
		Blood transfusion			3 or more miscarriages
		Hepatitis C			Melanoma, when
		HIV/AIDS			Basal or squamous cell carcinoma
		Herpes			Cancer, type
		Tuberculosis			Organ transplant
		MRSA			Personal or family history of malignant hyperthermia

Please list any other Medical Conditions you have not listed above:

_____

_____

Allergies:

Medication Allergies □ **No** □**Yes,** please list Medication Allergies OR Allergies to Substances AND SYMPTOMS (rash, etc.)

_____

_____

List all of the Medications (over the counter and prescription) you take regularly

Medication	Dosage	Frequency	Reason for Medication

□ **I do not take any medications**

If you take Opioids (pain medication) on a regular basis, are you in a contract with a Pain Management Specialist?
□ No □Yes, who _____

List all Major Surgeries and Hospitalizations

Surgery	Date

□ **I have not had any major surgeries or hospitalizations**

Do you see a Cardiologist? If yes, who _____
Women ONLY: When was your last Mammogram _____ Was it normal □No □ Yes

<u>Family History</u>: DO YOU HAVE ANY FAMILY HISTORY OF MEDICAL PROBLEMS? List All

_____

_____

Social History:
Do you Drink Alcohol □ **No** □ **Yes**, drinks per week _____
Do you Smoke Cigarettes □ **Never** □ **Former smoker**, quit when _____ □ Yes, cigarettes per day _____
Do you use any Nicotine Substance (chew, dip, gum, patches) □ **No** □ **Yes** _____
Do you smoke or use any form of Marijuana □ **No** □**Yes**, type and frequency _____
Do you use any Illicit Drugs □ **No** □ **Yes**, type and frequency _____
Have you ever been treated for Substance Abuse □ **No** □ **Yes**, when and type of substance _____
Occupation: _____

Review of Systems
CIRCLE ANY/ALL THAT APPLY TO YOU TODAY

General/Constitutional: Changes in appetite, Chills, Fever, Headaches, Weight gain, Weight loss.

Bad reaction to general anesthesia? No / Yes

Head/Eyes/Ears Nose/Throat: Blurry vision, Eye pain, Tearing excess, Decreased hearing, Snoring, Sore Throat.

Endocrine: Cold intolerance, Excessive thirst, Heat intolerance.

Respiratory: Cough, Shortness of breath, Wheezing.

Breast: Breast lump, Breast pain, Breast swelling, Nipple discharge, Rashes, Red skin.

Cardiovascular: Chest pain, Dizziness, Palpitations.

Gastrointestinal: Abdominal pain, Constipation, Diarrhea, Nausea, Vomiting.

Genitourinary: Blood in urine, Difficulty urinating.

Musculoskeletal: Muscle aches, Joint pain, Swollen joints.

Peripheral Vascular: Bleeding disorder, Blood clots, Pain/cramping in legs after walking

Skin/Integumentary: Scarring problems, Rash.

I understand that providing my full medical history and medication list is my responsibility. I attest that the information I have given today is correct and to the best of my knowledge.
Signature: _____ Date: _____

(Patient signature; parent or guardian signature if patient is a minor)

Leland H. Webb, MD, FACS

PATIENT INTEREST QUESTIONNAIRE

(Please Mark ALL that Apply)

Patient Name: _____

Date: _____

Face

- ☐ Facial skin/ Fine lines & Wrinkles
- ☐ Facial Plastic Surgery
- ☐ Facial fullness/drooping
- ☐ Facial contouring
- ☐ Nose size or shape
- ☐ Drooping brow
- ☐ Drooping eyelids
- ☐ Mole removal
- ☐ Scar revision
- ☐ Frown lines / fine lines / wrinkles
- ☐ Botox
- ☐ Sculptra (volumizer)
- ☐ Fillers (Juvederm/Restylane/Radiesse)
- ☐ Thin lips
- ☐ Collagen Therapy (Dermaroller)
- ☐ Laser Treatment (resurfacing)
- ☐ Chemical peel
- ☐ Brown spots/age spots/freckles/texture
- ☐ Skin care
- ☐ Other, please specify: _____

Upper Body

- ☐ Breast size / shape
- ☐ Ear size / shape
- ☐ Neck wrinkles
- ☐ Hands

Lower Body

- ☐ Abdominal area
- ☐ Hips complacency
- ☐ Body Contouring

Please describe your current skin care regimen

- ☐ Cleanser
- ☐ Moisturizer
- ☐ Sunscreen
- ☐ Anti-aging products

Are you a member of:

- ☐ Instagram
- ☐ Facebook
- ☐ Twitter
- ☐ Yelp

Would like to receive special offers from our office through our email newsletter?

Please circle one: YES / NO