

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In All Fields)

Patient's Name

Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? No Yes Contact Restrictions: _____

Email:

Age _____ Birthdate: / / SS# _____ - - Sex Female Male Race _____

Marital Status

Single Married Widowed **Spouse's Name:** _____ **Phone Number:** _____

Pharmacy Name: _____ **Phone Number:** _____

Primary Care Physician: _____ **Phone Number:** _____

Referring Physician: _____ **Phone Number:** _____

Patient's Employer: _____ **Occupation:** _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes No

Address _____
Street & Suite # City State Zip

Emergency Contact:

Home Phone _____ Cell Phone _____

Address _____
Street & Apt # City State Zip

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Lucas to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Lucas and myself.

Signature _____ **Date** _____

Health Questionnaire

LUNGS

	YES	NO
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>

HEART

Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
If yes, explain: _____		
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>

BLOOD

Bruise or bleed easily	<input type="checkbox"/>	<input type="checkbox"/>
Clotting disorder/DVT	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary embolism	<input type="checkbox"/>	<input type="checkbox"/>

LIVER

Drink alcoholic beverages	<input type="checkbox"/>	<input type="checkbox"/>
Other liver disease	<input type="checkbox"/>	<input type="checkbox"/>

KIDNEY

Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

NERVOUS SYSTEM

Abnormality of nervous system	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>

ENDOCRINE

Diabetes (blood sugar)	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>

AIRWAY

Problems opening mouth wide	<input type="checkbox"/>	<input type="checkbox"/>
Problems turning head	<input type="checkbox"/>	<input type="checkbox"/>

REPRODUCTIVE

Children? If so, how many? _____
Vaginal birth or C-section? _____

MUSCULOSKELETAL

Joint, tendon, or nerve damage	<input type="checkbox"/>	<input type="checkbox"/>
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Last mammogram: _____ Normal/Abnormal

Do you have any past or present health problems not indicated above? If yes, please describe:

Do any diseases run in your family? If so, name them: _____

Any history of mental illness? _____

SURGICAL HISTORY: List previous operations and approximate dates: _____

	YES	NO
Complications after surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Infection?	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

ANESTHETIC HISTORY

Nausea and/or vomiting?	<input type="checkbox"/>	<input type="checkbox"/>
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Other issues: _____

DRUG ALLERGIES: _____

What kind of reaction? _____

LIST ALL PRESENT MEDICATIONS

List any vitamins and/or herbal supplements you are presently taking:

Any other disclosures you feel may be important:

Signature: _____ Date: _____



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PATIENT NAME: _____ **DATE OF BIRTH:** _____

Please check the appropriate answer and sign below:

Do you smoke? Yes ___ **No** ___ **Do you vape? Yes** ___ **No** ___

Patient Signature _____
Date

If you answered “yes” to this question, please read the following. This information will be discussed with you during your office visit.

INFORMED CONSENT FOR PATIENTS WHO SMOKE/VAPE

As a smoker, I, _____, have been informed and understand that smoking and its subsequent physiological effects pose serious consequences for smokers undergoing medical treatment and undergoing or recovering from surgery.

Smoking decreases the supply of oxygen to tissues and a decreased oxygen supply delays wound healing. Nicotine is a vasoconstrictor that will reduce oxygen to tissues. Smoking interferes with healing of surgical wounds and may also lead to skin actually dying and requiring further treatment or surgery.

I understand that I should refrain from smoking three to four weeks prior to surgery and refrain from smoking after surgery and that risks are still increased to some extent.

I have read this informed consent document and understand the dangers of smoking prior to, during, and after my surgery and treatment.

Patient Signature _____
Date

Witness Signature _____
Date



PATIENT PRIVACY CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The Terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

This Consent was signed by: _____
Printed Name – Patient or Representative

Relationship to Patient (if other than patient): _____

Signature _____ Date ___ / ___ / _____

In front of _____ Signature _____
Printed Name- Practice Representative



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CONSENT FOR PHOTOGRAPHY

PATIENT NAME: _____ **RECORD #** _____

I understand that photographing and/or videotaping may be deemed appropriate as part of my/my child's evaluation and treatment by the physicians and staff of The Lucas Center. I understand and accept that I/my child may be recognized from my/my child's likeness or case history.

I authorize the physician of The Lucas Center, to use my/my child's photographs, videotapes and case information in educational and scientific settings, including lectures and multi-media presentations for an audience of healthcare professionals, at which members of the press may be present, and medical, surgical and scientific journal articles.

I authorize the use of my/my child's photographs and case information in the following educational/marketing settings: the practice's patient education materials; the file of pre- and post-operative patient photographs available to prospective patients for viewing; newspaper and magazine articles in which the practice's physician participates; the practice's web site; other web sites approved by the practice for education and marketing; and lectures and multi-media presentations given by the practice's physician to the general public.

In any case, it is specifically understood that I / my child shall not be identified by name.

I understand that this consent remains in effect until revoked by me in writing.

Therefore, I (initial one):

_____ give my permission for photographs, videotapes or case history to be used as described above.

_____ do not give my permission for photographs, videotapes or case history to be used as described above.

Signature (patient or legal guardian if minor)

Date

Witness signature

Date