THE LUCAS CENTER

(865) 218-6210

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:** _____

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 - Name: _____ **Relationship:** _____

Home Phone _____ Cell Phone _____ C

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 ☐ ☐
Asthma ☐ ☐
Emphysema ☐ ☐
Do you currently smoke? ☐ ☐
For _____ years? Packs Per Day: ____
Former smoker? ☐ ☐
When did you quit? _____
Do you vape? ☐ ☐

HEART
Heart disease ☐ ☐
If yes, explain: _____
High blood pressure ☐ ☐
Heart attack ☐ ☐

BLOOD
Bruise or bleed easily ☐ ☐
Clotting disorder/DVT ☐ ☐
Pulmonary embolism ☐ ☐

LIVER
Drink alcoholic beverages ☐ ☐
Other liver disease ☐ ☐

KIDNEY
Kidney disease ☐ ☐
Other: _____

NERVOUS SYSTEM YES NO
Abnormality of nervous system ☐ ☐
Stroke ☐ ☐

ENDOCRINE
Diabetes (blood sugar) ☐ ☐
If yes, what was your last AIC? _____
Thyroid disorder ☐ ☐

AIRWAY
Problems opening mouth wide ☐ ☐
Problems turning head ☐ ☐

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

LAST MAMMOGRAM:_____

MUSCULOSKELETAL
Joint, tendon, or nerve damage ☐ ☐

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? ☐ ☐
Infection? ☐ ☐
Other: _____

ANESTHETIC HISTORY
Nausea and/or vomiting? ☐ ☐
Other issues: _____

DRUG ALLERGIES/REACTIONS:
_____
_____

LIST ALL PRESENT MEDICATIONS – including vitamins and/or herbal supplements _____
_____
_____
_____
_____
_____
_____
_____

Any history of drug/opioid addiction? (this is for post surgery pain management purposes)
_____

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

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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**