Chart #_____

Patient's Name _____
First Middle Last

Address _____
Street & Suite # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒No ❒Yes May we send promotional text messages? ❒No ❒ Yes

Email Address _____

May we send promotional email messages? ❒No ❒ Yes

Birth Date_____ SS# _____ Gender ❒ Male ❒ Female

Marital Status ❒ Single ❒Married to: _____ ❒ Other

Patient's Employer _____ Occupation _____

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

How did you hear about Dr. Breazeale? (Mark all that apply)

❒TV News ❒TV Ad ❒Phone Book ❒Newsletter ❒Seminar ❒Salon ❒Web

❒ Friend/Relative: _____ ❒Doctor: _____ ❒Other: _____

Emergency Contact

Name _____Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Areas of Interest: (mark all that apply)

Facial Procedures
- ❒ Blepharoplasty (Eyelid Lift)
- ❒ Brow or Forehead Lift
- ❒ Earlobe Repair
- ❒ Face or Neck Lift
- ❒ Lip Enhancement
- ❒ Skin Resurfacing

Breast Procedures
- ❒ Breast Augmentation
- ❒ Breast Reduction
- ❒ Mastopexy (Breast Lift)
- ❒ Nipple Reduction or Inversion

Body Procedures
- ❒ Abdominoplasty (Tummy Tuck)
- ❒ Brachioplasty (Arm Lift)
- ❒ Liposuction
- ❒ Thigh or Buttock Lift

Other Procedures
- ❒ Skin Care
- ❒ Botox
- ❒ Wrinkle Fillers (Injections)
- ❒ Laser Hair Removal
- ❒ Skin Tightening
- ❒ Lesions / Moles
- ❒ Hand Rejuvenation

Could we schedule you for a complimentary skin evaluation? ❒ Yes ❒ No

I understand that office visit charges are payable on the day service is rendered.

Signature _____ Date _____

History and Physical

Patient's Name: _____ Age: _____

Height: _____ Weight: _____ Number of Children: _____

Part I History

The following questions are to be filled out by the patient. Check box YES or NO. Any positive response will be discussed with you by your doctor.

Lungs	Yes	No
Born with any lung disease	❒	❒
Cough or cold (at present)	❒	❒
Bronchitis	❒	❒
Asthma	❒	❒
Emphysema	❒	❒
Do you Smoke?	❒	❒

❒ Nicotine ❒ Vape ❒ Marijuana

Heart		
Born with any heart disease	❒	❒
Heart murmur	❒	❒
High blood pressure	❒	❒
Skipped heart beats	❒	❒
Chest pain	❒	❒
Hardening of the arteries	❒	❒
Heart failure	❒	❒
Heart attack	❒	❒
Rheumatic fever	❒	❒

Blood		
Do you bruise or bleed easily	❒	❒
Abnormal bleeding (of any kind) in family	❒	❒
Sickle cell trait/disease	❒	❒
Other blood cell disease	❒	❒
Prolonged bleeding with tooth extraction	❒	❒

Liver		
Drink alcoholic beverages	❒	❒
Hepatitis	❒	❒
Jaundice	❒	❒
Other liver disease	❒	❒
Any history of mental illness	❒	❒

Nervous System	Yes	No
Born with abnormality of nervous system	❒	❒
Brain disease	❒	❒
Spinal cord disease	❒	❒
Nerve disease	❒	❒
Epilepsy	❒	❒

Endocrine		
Diabetes (blood sugar)	❒	❒
Thyroid disorder	❒	❒

Eye		
Glaucoma	❒	❒
Contact lenses	❒	❒

Stomach, bowel, gallbladder		
Any disease of?	❒	❒

Airway		
Problems opening mouth wide	❒	❒
Problems turning head in any direction	❒	❒

Reproductive		
Female: are you pregnant?	❒	❒
Planning pregnancy preoperatively?	❒	❒
Have you breast fed in the last 3 months?	❒	❒

Musculoskeletal		
Any injury or damage to:	❒	❒
Joints	❒	❒
Tendons	❒	❒
Nerves	❒	❒

Patient's Name: _____ Date: _____

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 the disease:_____
_____
_____

Surgical History:
List previous operations and approximate dates:

_____
_____
_____

Have you ever had complications after surgery?

	YES	NO
Bleeding or blood clot	❒	❒
Infection	❒	❒

Other:_____
_____
_____

Anesthetic History:
Date of last general anesthetic: _____
Any problems resulting from any local or general anesthetic ever administered to you?

	YES	NO
Nausea and/or vomiting?	❒	❒
Any family members with problems related to anesthesia?	❒	❒

If you answered yes, please explain:

_____
_____
_____
_____

Latex Allergy? ❒ Yes ❒ No

Drug Allergies (List):
What kind of reaction?:

_____
_____

Who is your primary care physician?

_____
City: _____
Phone number: _____

List ALL present medications: (By name and the reason for taking them). Especially important are: Cortisone, hormones or birth control pills, cold medications, aspirin or aspirin containing medications, tranquilizers, sedatives, antidepressants, blood thinners (anticoagulants), heart medications, and water pills (diuretics).

_____
_____
_____
_____
_____

	YES	NO
Any history of Arthritis?	❒	❒

If so, type of Arthritis: _____

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

_____
_____

Preferred Pharmacy: _____

_____

Pharmacy Phone number: _____

Patient Acknowledgement of Receipt of Notice of Privacy Practices

I hearby acknowledge that a copy of this medical practice's Notice of Privacy Practices is available upon request.I further acknowledge that I am entitled to a hard copy of this information upon my request. In addendum, I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I understand that any change I wish made to this acknowledgement must be done so by me in writing. This includes the addition or deletion of any person or persons I have authorized the release of information to.

Chart # _____

Patient Full Name: _____
(Please Print)

Signature: _____
(Patient or legal guardian. Please specify relationship, if not the patient)

The following individuals have my written consent and permission to speak with The Breazeale Clinic staff regarding my care.

Full Name and Relationship _____

Full Name and Relationship _____

This authorization and acknowledgment expires_____
(If "none" is indicated as the expiration date, you will not be asked to update the form again unless there is a change in the privacy practices, or you amend your authorization)

You have the right to refuse to sign this acknowledgment and authorization. If you refuse, please indicate the reason for refusal:
_____
_____

Patient Photographic Authorization

I, _____ authorize Dr. Ed Breazeale or staff of The Breazeale Clinic to photograph me or parts of my body for medical purposes related to my care. These photos would be taken pre and postoperatively and would be included as a confidential part of my medical record.

These photos will not be published in print or any electronic media without my written consent to do so.

I understand that should The Breazeale Clinic elect to use my photos for reasons such as patient education or marketing to the general public, I would be notified and must give my written permission on a separate photographic authorization and consent.

Printed Name of Patient or Legal Guardian Date

Signature of Patient or Legal Guardian Date

Chart #_____

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

When you schedule an appointment with The Breazeale Clinic we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective September 1, 2018 any established patient who fails to show or cancel/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged a **$25.00 fee.**

- Any established patient who fails to show or cancels/reschedules an appointment without a 24 hour notice a second time will be charged a **$50.00 fee.**

- If a **third** No Show or cancellation/reschedule with no 24 hour notice should occur, the patient may be **dismissed** from The Breazeale Clinic.

- Any new patient who fails to show for their initial visit will not be rescheduled.

- Any patient who arrives **7 minutes or more** after their scheduled appointment time will be rescheduled.

- The fee is charged to the patient and is **due at the time of the patient's next office visit.**

- As a courtesy, we make reminder calls, texts and/or emails for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee.

I have read and understand the medical appointment cancellation/no show policy and agree to its terms.

_____ _____

Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date