

Date \_\_\_\_\_

Referring Physician \_\_\_\_\_

*Denton Watumull, M.D.*

*Bruce Byrne, M.D.*

*Joshua Lemmon, M.D.*

### **PATIENT REGISTRATION**

#### **PATIENT INFORMATION:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widow \_\_\_\_\_

Sex: Female \_\_\_\_\_ Male \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alternative Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_

Please add me to your mailing list for Events and Spa Specials.  Yes  No

Student Status: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Not A Student \_\_\_\_\_

#### **GUARANTOR (Primary Insured):**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Guarantor's address if different from patient's: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Sex: Female \_\_\_\_\_ Male \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

E-mail: \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employment Status: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Not Employed/Retired \_\_\_\_\_

Occupation: \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

**EMERGENCY CONTACT: (Any person not residing with patient)**

Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail \_\_\_\_\_

**CONTACT CONSENT**

I, \_\_\_\_\_, the undersigned patient, authorize Regional Plastic Surgery Associates to contact me at the following numbers:

**A). Via Phone:**

**At Home:** Yes \_\_\_\_\_ No \_\_\_\_\_ Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
**At Work:** Yes \_\_\_\_\_ No \_\_\_\_\_ Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
**Cell Phone:** Yes \_\_\_\_\_ No \_\_\_\_\_ Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**B). Can Leave Message At:**

**At Home:** Yes \_\_\_\_\_ No \_\_\_\_\_  
**At Work:** Yes \_\_\_\_\_ No \_\_\_\_\_  
**Cell Phone:** Yes \_\_\_\_\_ No \_\_\_\_\_

**C). Other Persons We May Leave A Message With:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**INSURANCE AUTHORIZATION AND ASSIGNMENT:**

I hereby authorize Denton Watumull, M.D., Bruce Byrne, M.D., and/or Joshua Lemmon, M.D., to furnish information to insurance carriers concerning my illnesses, accidents and treatments, and also assign to them all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I also understand that any additional copay, coinsurance, and/or deductibles are due at the time of service.

This office will request a surgery deposit of \$250.00. In case of overpayment, you will be refunded after your insurance pays the surgery bill.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Patient's signature or responsibility party)

**Notice Concerning Complaints**

Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation to the following address:

Texas State Board of Medical Examiners  
Attn: Investigations  
Centre Creek Drive, Suite 300  
Austin, TX 78714-9134  
1-800-201-9353

Name \_\_\_\_\_

Date \_\_\_\_\_

### NEW PATIENT INFORMATION

Age: \_\_\_\_\_ Are you RIGHT or LEFT handed? (circle one) R L

REASON FOR TODAY'S VISIT: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

PRIOR TREATMENT OR STUDIES FOR THIS PROBLEM: \_\_\_\_\_

\_\_\_\_\_

REFERRED BY: \_\_\_\_\_ PRIMARY DOCTOR: \_\_\_\_\_

#### PAST MEDICAL HISTORY

Melanoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	AIDS or HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding Tendency	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bad Scarring/Keloids	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lung Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stomach Ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Do you have SLEEP APNEA?  Yes  No

Have you had BLOOD CLOTS (DVT, pulmonary embolism)?  Yes  No

Other conditions/problems: \_\_\_\_\_

#### PRIOR OPERATIONS

Tonsillectomy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gastrointestinal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hand or arm	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Appendectomy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hysterectomy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney/Bladder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia repair	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Other operations: \_\_\_\_\_

\_\_\_\_\_

#### FAMILY HISTORY

Breast cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

\_\_\_\_\_

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**Do you smoke?**  Yes  No **How much?** \_\_\_\_\_ **How many years?** \_\_\_\_\_

**If you quit smoking, when did you quit?** \_\_\_\_\_

**Do you drink alcohol?**  Yes  No **If yes,**  rarely  socially  daily  heavily

**Do you take any non-prescription or illicit drugs?**  Yes  No

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**Do you have any of the following problems?**

Weight change  Yes  No Swollen feet  Yes  No Seizures  Yes  No  
Dry eyes  Yes  No Skin rash  Yes  No Joint/Muscle Pain  Yes  No  
Chronic cough  Yes  No Chronic Diarrhea  Yes  No Swollen Lymph Nodes  Yes  No  
Chest pain  Yes  No Jaundice  Yes  No Easy Bleeding  Yes  No  
Rapid heart beat  Yes  No Depression  Yes  No Easy Bruising  Yes  No  
Shortness of breath  Yes  No

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**DO YOU HAVE ANY MEDICATION ALLERGIES?**  Yes  No  
(Hives, welts, severe itching, facial/oral/airway swelling)

If yes, please list: \_\_\_\_\_  
\_\_\_\_\_

**DO ANY MEDICATIONS CAUSE ADVERSE SIDE EFFECTS FOR YOU?**  Yes  No  
(Nausea, vomiting, dizziness, stomach discomfort, confusion)

If yes, please list: \_\_\_\_\_  
\_\_\_\_\_

**LIST ALL CURRENT MEDICATIONS (INCLUDING OVER-THE-COUNTER/HERBAL)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ARE YOU CURRENTLY WORKING?**  Yes  No **JOB TITLE:** \_\_\_\_\_

**IF YES, IN WHAT CAPACITY?**  Full duty  Light duty

**DO YOU HAVE ANY CURRENT WORK RESTRICTIONS?**  Yes  No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Reviewed: \_\_\_\_\_

Sign/Date

Dr. Watumull

Dr. Byrne

Dr. Lemmon

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Date: \_\_\_\_\_

TO WHOM IT MAY CONCERN:

I authorize the release of all my medical records with your office to

- Dr. Denton Watumull       Dr. Joshua Lemmon
- Dr. Bruce Byrne

A photocopy of this will be considered as valid as the original.

\_\_\_\_\_  
Patient Signature (or guardian)