

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: (____) _____ - _____

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: _____

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: (____) _____ - _____

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 | | | |

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

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

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



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)