



# PATIENT INFORMATION SHEET

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
First Middle Last

ADDRESS \_\_\_\_\_  
Street City State Zip

SOCIAL SECURITY NUMBER \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

MARRIED  SINGLE  DIVORCED  WIDOWED  SEPARATED SEX  M  F

SPOUSE'S NAME \_\_\_\_\_

YOUR HOME PHONE \_\_\_\_\_ YOUR WORK PHONE \_\_\_\_\_

YOUR CELL PHONE \_\_\_\_\_ YOUR EMAIL ADDRESS \_\_\_\_\_

PREFERRED METHOD OF CONTACT (PLEASE RATE 1-4) \_\_\_ HOME \_\_\_ WORK \_\_\_ CELL \_\_\_ EMAIL

IN CASE OF AN EMERGENCY, PLEASE LIST NAME, PHONE NUMBER AND RELATIONSHIP OF PERSON TO YOU:

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

PATIENT'S OCCUPATION \_\_\_\_\_ EMPLOYER'S NAME \_\_\_\_\_

HOW WERE YOU REFERRED TO US: (CHECK ALL THAT APPLY)

PHYSICIAN (FULL NAME) \_\_\_\_\_  FRIEND'S NAME \_\_\_\_\_

Indianapolis Woman Magazine  Website  Yellow Pages  Television/Radio  Indianapolis Monthly

Other \_\_\_\_\_

FAMILY PHYSICIAN (PC) \_\_\_\_\_  
PHONE \_\_\_\_\_

REASON FOR YOUR VISIT TODAY \_\_\_\_\_

**INSURANCE INFORMATION:** Please complete all blanks and have your insurance card available for the receptionist to make a copy. Thank you.

PRIMARY INSURANCE COMPANY \_\_\_\_\_ MEMBER'S NAME \_\_\_\_\_

MEMBER'S SOCIAL SECURITY NUMBER \_\_\_\_\_ MEMBER'S DATE OF BIRTH \_\_\_\_\_

MEMBER'S EMPLOYER \_\_\_\_\_

SECONDARY INSURANCE COMPANY \_\_\_\_\_ MEMBER'S NAME \_\_\_\_\_

MEMBER'S SOCIAL SECURITY NUMBER \_\_\_\_\_ MEMBER'S DATE OF BIRTH \_\_\_\_\_

MEMBER'S EMPLOYER \_\_\_\_\_

**PLEASE SIGN BELOW:**

**MEDICAL INSURANCE RELEASE:**

I authorize the release of all necessary medical information, including photographs, to process any claim for services provided by Associated Plastic Surgeons of Indiana, PC. I further authorize my insurance company to release all medical benefits to Associated Plastic Surgeons of Indiana, PC, dba Turkle & Associates Cosmetic and Reconstructive Surgeons. A copy of this authorization may be used in place of the original.

\_\_\_\_\_  
Signature (if child, responsible party)

\_\_\_\_\_  
Date

**MEDICARE REQUIRES A ONE-TIME AUTHORIZATION, PLEASE READ AND SIGN BELOW**

I request Medicare and/or Medicaid benefits to be paid to me, or on my behalf to Associated Plastic Surgeons of Indiana, PC, dba Turkle and Associates Cosmetic and Reconstructive Surgeons. I authorize any party possessing my personal medical information, to release to the health care financing administration and its agents all information needed to determine benefits, or to determine the benefit payment for related services.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**PHOTOGRAPH RELEASE**

I authorize Associated Plastic Surgeons of Indiana, PC, dba Turkle & Associates to use my pre- and post-operative photographs, in connection with my medical or cosmetic services, for educational and medical purposes. I understand Turkle & Associates will not identify me by name when using my photographs.

\_\_\_\_\_  
Signature (if child, responsible party)

\_\_\_\_\_  
Date

**PATIENT FINANCIAL RESPONSIBILITY**

I accept financial responsibility for any products or services rendered by any member of Associated Plastic Surgeons of Indiana, PC, dba Turkle & Associates. If a claim is submitted to my insurance company, I accept financial responsibility for any portion not covered by my insurance. If it becomes necessary for Turkle & Associates to pursue collection, I agree to be responsible for any costs associated with collection, including but not limited to court costs and reasonable attorney's fees. I understand that there is a cancellation fee for any missed appointment that the office is not given 24 hour notice and I accept responsibility for that fee. I further understand that there is a fee of \$27.50 for any returned check and I accept responsibility for this fee.

\_\_\_\_\_  
Signature (if a child, responsible party)

\_\_\_\_\_  
Date

### PATIENT'S PERSONAL HISTORY

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

Confidential record: Information contained here will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your doctor in making decisions regarding your care.

**PATIENT INFORMATION:**

NAME: \_\_\_\_\_

LAST FIRST MIDDLE

AGE: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

SURGICAL OPERATIONS AND DATES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING: (Please circle answers)**

Y	N	STROKE	Y	N	MIGRAINE	Y	N	RHEUMATIC HEART
Y	N	CANCER	Y	N	HAY FEVER	Y	N	BLEEDING TENDENCY
Y	N	LEUKEMIA	Y	N	COLITIS	Y	N	HIGH BLOOD PRESSURE
Y	N	TUBERCULOSIS	Y	N	GOITER	Y	N	CONGENITAL HEART
Y	N	BRONCHITIS	Y	N	BLADDER INFECTION	Y	N	DEPRESSION
Y	N	EPILEPSY	Y	N	ASTHMA	Y	N	AIDS/HIV
Y	N	PNEUMONIA	Y	N	HEART ATTACK	Y	N	THYROID CONDITION
Y	N	DIABETES	Y	N	STOMACH ULCERS	Y	N	LUPUS
Y	N	HEPATITIS	Y	N	KIDNEY DISEASE	Y	N	FIBROMYALGIA
Y	N	OSTEO-ARTHRITIS	Y	N	TONSILITIS	Y	N	RHEUMATOID ARTHRITIS
Y	N	FIBROCYSTIC DISEASE	Y	N	COLD SORES	OTHER: _____		

Does any family member have a history of the listed diseases? YES \_\_\_\_\_ NO \_\_\_\_\_; IF YES, Please Specify: \_\_\_\_\_

Do you regularly smoke? Y \_\_\_\_\_ N \_\_\_\_\_; If yes, How Much? \_\_\_\_\_

Do you use nicotine products (such as patches, gums, etc) Y \_\_\_\_\_ N \_\_\_\_\_;  
If ever, when did you quit? \_\_\_\_\_

Do you regularly drink alcohol, beer, or wine? Y \_\_\_\_\_ N \_\_\_\_\_; If yes, how much? \_\_\_\_\_

**PATIENTS CONSULTING FOR BREAST SURGERY--Please complete this section, all others skip to page 2:**

Date of last Mammogram: \_\_\_\_\_

Where done? \_\_\_\_\_ Results? \_\_\_\_\_

Family history of Breast Cancer:	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

Personal history of Breast Cancer? Yes \_\_\_\_\_ No \_\_\_\_\_ Date: \_\_\_\_\_  
Side: Left \_\_\_\_\_ Right \_\_\_\_\_ Both \_\_\_\_\_

Other Previous Breast Surgery: \_\_\_\_\_

Number of pregnancies? \_\_\_\_\_ Complications during pregnancy? YES \_\_\_\_\_ NO \_\_\_\_\_  
If YES, Please specify: \_\_\_\_\_

Number of live births: \_\_\_\_\_ Did you nurse? YES \_\_\_\_\_ NO \_\_\_\_\_ Number of children breastfed: \_\_\_\_\_

**MEDICATION RECORD:**

YES \_\_\_\_\_ NO \_\_\_\_\_ Do you take aspirin/anti-inflammatory regularly? (IBUPROFEN, ALEVE, ETC)

**ALLERGIES TO MEDICATIONS:** (Please List)

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YES \_\_\_\_\_ NO \_\_\_\_\_ Do you take herbs, vitamin supplements or over the counter medication?

If Yes, please list:

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**Please list any Prescription Medications you are currently taking:**

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone Number: \_\_\_\_\_

Name of Medications (Brand or Generic Name)	Dosage (mg)	How Often?	Purpose of Medication	Employee Initial & Date

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

# TURKLE

associates

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