

Patient Information as of ____/____/____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name

First

Middle

Last

Address

Street & Apt #

City

State

Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? No Yes E-mail _____

Preferred Contact #

Age _____ Birthdate ____/____/____ SS# ____ - ____ - ____ Gender Female Male

Marital Status Single Married to: _____ Other: _____

Patient's Employer

_____ Occupation _____

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

Address _____

Street & Suite #

City

State

Zip

How did you hear about *Ellen Mahony, MD, LLC*?

(Please be specific)

- Website _____ Event _____ Radio _____ Magazine _____
- Friend/Family _____ Doctor _____ Newsletter _____ Seminar _____
- CareCredit Newspaper Allergan Yellow Pages Other _____

Was a female surgeon a factor in your decision today? Yes No

Emergency Contact

_____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Area of Interest

Are you now or have you ever been treated for a condition involving:

- Heart/Lungs Asthma/Bronchitis Sinus Trouble Psychiatric Care
- High Cholesterol Nervous System Muscle or Joints Depression
- Diabetes Liver Disease Anemia Obesity
- Immune System Disorder Gastrointestinal Tract Cancer Skin
- Blood Clotting Disorder Excessive Bleeding/Bruising High Blood Pressure Drug Abuse
- Check here if none apply Other _____

Allergic to Medications? Yes No Penicillin Other _____ Foods? Yes No Type _____

Latex? Yes No Adhesives? Yes No Please list any other allergies _____

Do you take any: Aspirin? Yes No Blood Thinning Agents? Yes No Cortisone/Steroids? Yes No

Do you smoke? Yes No How Much? _____ Drink Alcohol? Yes No How Much? _____

Height _____ Weight _____ Date of Last Physical ____/____/____ Primary Care Physician _____

Primary Care Physician Telephone Number _____ Do you consider yourself to be in good health? Yes No

Have you ever been hospitalized? Yes No Month/Year _____

Reason, please list _____

Have you ever had any surgical operations? Yes No Cosmetic Surgery? Yes No

If so, please list _____

Any problems with anesthesia? Yes No If yes, please explain _____

Please list any medications that you are presently taking, including over the counter drugs: _____

Vitamins/Herbal Supplements? Yes No Please List _____

Family Medical History _____

FEMALE PATIENTS ONLY

Are you pregnant? Yes No # Pregnancies _____ # Children _____ Method of Birth Control _____

Problems w/ Breasts? Yes No If yes, please list _____ Last Mammogram ____/____/____

Menstruating? Yes No Menopausal? Yes No Last Pap smear ____/____/____ Bra Size _____

How do you plan to cover the costs of this procedure? Own Funds? Yes No Credit Card? Yes No

Care Credit? Yes No Insurance? Yes No

Would you like to find out more about our finance plans? Yes No

Have you ever been involved in a malpractice lawsuit? Yes No

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND RENDER CARE.

I have answered the above questions concerning my health to the best of my knowledge. I hereby authorize Ellen A. Mahony, MD., permission to examine me and to render appropriate care at this time. Additional consents may be required as is appropriate for specific procedures. In addition, I hereby authorize release of any pertinent information to my insurance company for the purpose of obtaining insurance coverage for a procedure or to another medical practitioner or facility for the purpose of completing the medical record.

SIGNED _____

DATE ____/____/____