WILLIAMSBURG PLASTIC SURGERY
JOHNSTUART M. GUARNIERI, M.D.
American Society of Plastic Surgery

Patient's Full Name ____
Date of Birth ______/_____/______ Age ______ Male_____ Female_____ Social Security # ____________________
Driver License #/ State ______________________________________ Marital Status ___________________________
Address____
Street City State Zip
Home Telephone # (______)_________________________ Cell Phone # (______)______________________________
Email Address ____
Patient's Employer ________________________________ Work Telephone # (______)_________________________
Spouse's Name ___________________________________ Spouse's Employer________________________________

How did you hear about us? ____

Is this visit: The result of an accident? Y / N Motor vehicle related? Y / N Work related? Y / N

Nearest Relative/ Friend ***not*** living with you: Name/Relationship ________________________________
Address ________________________________
Phone Number________________________________

Person to Notify in Case of Emergency: Name/ Relationship ________________________________
Phone Number ________________________________

Primary Care Physician: Name ________________________________
Address ________________________________
Phone Number ________________________________

Primary Insurance: Company ________________________ Address ____________________________________
Phone Number ____________________ Policy # ___________________ Group #______________
Insurer's Name ____________________ Insurer's SSN _______________ Relationship __________

Secondary Insurance: Company ________________________ Address ____________________________________
Phone Number ____________________ Policy # ___________________ Group #______________
Insurer's Name ____________________ Insurer's SSN _______________ Relationship __________

I authorize the release of information to the insurance company(s) named above as well as my referring / primary care physician and request that payments of medical benefits be paid directly to WPS. I understand that I am responsible for any balance left unpaid by my insurance company. I understand and agree that WPS obtaining insurance proceeds from my insurance company is a gratuity only and I agree to make payments myself if my insurance does not pay within a reasonable amount of time. If collection procedures are required and instituted against me, I agree to pay all the costs of collection including, but not limited to, the 33 1/3% attorney fees for obtaining an unpaid balance and 18% interest per annum from the due date of the bill. I also understand that I will be responsible for getting referrals to WPS and agree to pay any balance denied by my insurance company(s) for not having a referral.

Signature ____**Date** ________________________________

Reason for Consultation (in your own words, what is it that that you would like to see changed and in what way?)

____

____

____

Desire for Cosmetic Enhancement? Y / N What type? ____

Desire for Dermal Fillers? Y / N Type? Botox Juvederm Restylane Scupltra Interested in Latisse? Y / N

Height _____ft. _____in. Weight _____lbs. My normal weight is _____lbs. Last time at this weight _____________

Allergies or Intolerance to Medications ____

Medications taken daily, including name, dosage, and length of time ________________________________

____

____

Over the Counter Medications taken regularly, including aspirin, diet pills, sleeping pills, vitamins, herbs, etc. __________

____

____

____

Drug Dependence Y / N Alcohol Dependence Y/ N

Previous Surgery ____

____

Anesthesia Problems (*nausea/ vomiting, slow to wake up, high temperature*) ____________________________

____

Past Hospitalizations (*please include childbirth*) ____

____

____

Have you ever had?

Hepatitis/ Jaundice Yes _____ No _____ Any recurrences? When? ________________________________

Epilepsy/ Seizures Yes _____ No _____ Thyroid Problems Yes _____ No _____

High Blood Pressure Yes _____ No _____ Ulcers Yes _____ No _____

Heart Disease Yes _____ No _____ Migraines Yes _____ No _____

Heart Attack Yes _____ No _____ Cold Sores Yes _____ No _____

Mitral Valve Prolapse Yes _____ No _____ Stroke Yes _____ No _____

Prior Blood Transfusion Yes _____ No _____ Diabetes Yes _____ No _____

Psychiatric Problems Yes _____ No _____ Kidney Problems Yes _____ No _____

Arthritis Yes _____ No _____ Anemia Yes _____ No _____ Currently? Y / N

Keloids Yes _____ No _____ Sexually Transmitted Disease Yes _____ No _____

Emphysema, Asthma, Shortness of Breath Yes _____ No _____

Abnormal Bleeding Yes _____ No _____ When ____

Cancer Yes _____ No _____ Type ____

Have you or any family member had any breast cancer? Yes _____ No _____

If yes, please explain ____

Have you or any family member had any history of skin cancer including basal cell, squamous cell, or melanoma?

Yes _____ No _____ If yes, please explain (including who and location on the body) ________________________

____

Date of Last Physical ___________________ Physician's Name _____________________ Finding ______________________
Date of Last EKG ______________________ Date of Last Blood Work _____________________
Do you drink alcohol? Yes _____ No _____ How much and how often? ____________________________________
Do you smoke? Yes _____ No _____ For how long? ______________ How many packs per pay? ____________
If you have stopped smoking, for how long have you quit? ____
Do you use any other tobacco products or use a nicotine patch? Yes _____ No _____ Type _________________________
Do you use recreational/ IV drugs? Yes _____ No _____ Type ____

Have you had any testing for the following?

Tuberculosis	Yes _____	No _____	Date ______________	Results ______________________________________
HIV	Yes _____	No _____	Date ______________	Results ______________________________________
Hepatitis	Yes _____	No _____	Date ______________	Results ______________________________________

Condition of Teeth
Caps/ Dentures Yes _____ No _____ Problem Teeth ____

Female Patients Only
Are you pregnant? Yes _____ No _____ Date of Last Menstrual Period ___________________________________
Children (please include names and ages) ____
____
Did you breast feed? Yes _____ No _____ For how long? ____
How did your breasts change after breast feeding? ____
Breast Lumps Yes _____ No _____ Biopsies Yes _____ No _____ Results ____________________
Date of Last Mammogram __________________ Findings ___________________ Location ___________________________

The law in Virginia provides that whenever any person who is rendering health care services to a patient is directly exposed to the patient's body fluids in a manner that may, according to the current guidelines of the Center for Disease Control, transmit human immunodeficiency virus (AIDS) or Hepatitis B or C viruses, that patient will be deemed to have consented to testing for infection with the AIDS virus, Hepatitis B or C viruses. This means that that patient may be tested for infection with the AIDS virus, Hepatitis B or C viruses without actual consent but with knowledge. The results of this test will be released to the person who is exposed to body fluids, also without actual consent.

Photo Release: Medical photographs and/or video tapes may be taken before, during, and after a surgical procedure or treatment. Consent is required to take such images. Additionally, patients may consent to release these medical photographs and/or videotapes for a stated purpose, such as patient education, before and after gallery, and/or insurance requests.
I hereby authorize Dr. Johnstuart M. Guarnieri and his associates or licensees to take pre-operative, intra-operative, and post-operative photographs and/or videotapes. I additionally authorize photographs and/or videotapes of my interview.
I hereby authorize you to release my medical records to insurance companies.
This authorization will expire upon written request by the patient.

1.) The above information is current and correct to the best of my knowledge.
2.) If computer imaging is used in my evaluation, I understand that the alterations is purely for the purpose of illustration and discussion and in no way constitutes an expressed or implied warranty as to my final results and appearance.

Signature ____ **Today's Date** _____/_____/_____
(Relationship to Patient)