

St. Petersburg Center for Plastic Surgery

JOHN J. O'BRIEN, Jr., M.D.

Social Security # _____ Date _____

Patient's Name _____
(First) (Middle Initial) (Last)

Age _____ Date of Birth _____ Married _____ Single _____ Widowed _____ Divorced _____ Separated _____

Local Address _____

City _____ State _____ Zip _____ Phone w/Area Code _____

Permanent Address _____

City _____ State _____ Zip _____ Phone w/Area Code _____

Patient's Occupation _____ Employer _____

Business Address _____ Bus. Phone _____ Ext. _____

Name of Spouse _____ Spouse Occupation _____

Spouse Employer _____ Bus. Phone _____ Ext. _____

Patient Referred By _____ Email address: _____

Family Doctor or Primary Care Physician _____ Phone w/Area Code _____

Has our office seen/treated any member of your family? No _____ Yes _____ If "yes", whom? _____

Emergency contact name and phone _____

Please Check: Group Insurance _____ Medicare _____ Workman's Comp. _____ Accident _____

Insurance Company _____ Phone w/Area Code _____

Please Submit Insurance Card to Receptionist for Copy

If Workman's Compensation:

Date of Injury _____ Employer _____ Phone w/Area Code _____

If Accident:

Date of Injury _____ Insurance Co. _____ Phone w/Area Code _____

Person Financially Responsible: Patient _____ Spouse _____ Other _____

If "Other", please complete the following:

Name _____ Relationship _____

Address _____

Occupation _____ Employer _____ Phone w/Area Code _____

Will you be paying for today's services by: Cash _____ Check _____ Visa/MC/Amex/Discover _____

Specific reasons/interest(s) for which you are seeing Dr. O'Brien today: _____

Have you consulted with any other doctors, including plastic surgeons about this? No _____ Yes _____
If "yes", please list their names _____

INJURIES

Type	Date	Hospital	Doctor	After Effects

FAMILY HISTORY

Age	State of Health	Please check if there is a history of the following in your family and who it affected -	
Mother _____	_____	Tuberculosis _____	No _____ Yes _____
Father _____	_____	Cancer _____	No _____ Yes _____
Brother(s) _____	_____	Diabetes _____	No _____ Yes _____
_____	_____	Epilepsy _____	No _____ Yes _____
Sister(s) _____	_____	Heart Disease _____	No _____ Yes _____
_____	_____	High Blood Pressure _____	No _____ Yes _____
Children _____	_____	Lung Disease _____	No _____ Yes _____
_____	_____	Kidney Disease _____	No _____ Yes _____
_____	_____	Blood Disease _____	No _____ Yes _____
_____	_____	Asthma _____	No _____ Yes _____
_____	_____	Mental Disease _____	No _____ Yes _____

MEDICATIONS, DRUGS

What is your approximate daily consumption of the following:

Tobacco _____

Alcohol _____

Coffee or Tea _____

Please list all medications you are now taking (including birth control pills, diuretics (water pills), blood pressure or heart medications, tranquilizers, hormones, blood thinners, Coumadin, aspirin containing products, herbal supplements or diet medications.
