Plastic Surgery Institute of New Mexico

Patient Information

Neil T. Chen, MD, Medical Director
Christopher D. Knotts, MD, FACS

Last Name:_____First Name:_____Mid. Init._

Date of Birth_____Age_____Occupation_____

Referral by ( ) friend/family _____ ; ( ) web research; ( ) doctor _____; ( ) magazine; ( ) other _____

Address:_____

City_____State_____Zip_____

Phone (home)_____; (work)_____; (mobile)_____ Circle the best contact number

Preference of appointment reminder: __ email, or __ text messaging: cell phone carrier: _____

e-mail_____ May we email you reminder/ communication? Y / N

Person to contact in an emergency_____Phone_____Relation_____

Family physician _____ When was your last physical exam? _____

Topic for consultation today:_____

Acknowledgement of Receipt of HIPPA Policy

I hereby acknowledge that I have read and have the opportunity to receive a copy of this practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.
Enter email address if you would like to receive a copy of amended Notice of Privacy by e-mail:
If not signed by patient, indicate relationship: __ parent or guardian of minor patient, __ guardian or conservator of an incompetent patient

By signing below:

I verify that the information I provide is complete, true, and correct to the best of my knowledge
I agree to comply fully with my care, instruction, treatment and medication prescribed to me
I authorize the release of medical information to and from Dr. Chen deemed medically necessary for my treatment.
I agree to be responsible for all financial charges incurred as a result of my evaluation and treatment. Outstanding balance after 60 days is subject to monthly finance charge of 1.5% per month. I understand that the cost of collection in case of delinquency (90 days past due) will be added to my account.
I acknowledge that there is a non-refundable and non-transferable scheduling fee when you book a surgical procedure. There is possible cancellation fee as described in the "Quote" document which you will receive.
I waive my privacy right under HIPPA for the verification of service provided to the third party payer if financial disputes arise.
I further acknowledge all refunds for funds paid with credit cards are subject to deduction of processing fees of 2.5%.
I agree that a copy of this document bearing my signature has the same effect as the original

Patient signature_____Date_____

SANDIA SURGERY CENTER PRE-OP QUESTIONNAIRE

Todays Date ___ /___ /___

Name: _____ Age:_____ Date of Birth ___ /___ /___ Height _____ Weight _____ lbs

Contact Phone - Home/Cell: _____ Work: _____ Occupation:_____

Medications (including supplements, herbal and over the counter) _____

_____

_____

_____

Allergies: NONE Penicillin Keflex Sulfa Bactrim Septra Erythromycin Iodine Latex Other:_____

_____

Prior Surgeries / Hospitalizations _____

_____

_____

For Women Only: Pregnancies #:_____ Children # _____. Last Mammogram Date: ___ / ___ / ___ Results_____

ANY MEDICAL HISTORY OF	NO	YES	IF "YES" CHOSEN, CIRCLE or FILL IN APPROPRIATE ANSWER/CONDITION
Any **LUNG** problems ?			Asthma COPD Emphysema Pneumonia Cystic Fibrosis Home O2 use shortness of breath Pulmonary Embolus Other diagnosis _____ Steroid use for Asthma (yes) (no) Emergency room visits for Asthma ? (Yes) (No)
Prior or current **SMOKING** or Vaping ?			Current Cigarettes Packs per day _____. Vaping (number of years)_____ Quit for _____ weeks/months/years
SLEEP APNEA ?			Years of diagnosis _____ Do you use CPAP ? (Yes). (No)
HYPERTENSION (High blood pressure) ?			Years of diagnosis _____ Treated ? (Yes) (No)
HEART problems ?			Have you even seen a Cardiologist ? (YES) (NO) when ?_____ Heart Valve. Arrhythmia. Chest pain Angina Stents Heart Attack (MI) Heart Failure Pacemaker AICD Other:_____
STOMACH or GI problems ?			Hiatal Hernia GERD (Reflux) Stomach Ulcers Liver Cirrhosis Intestinal or other problems _____
KIDNEY problems ?			Kidney stones Infection Renal Failure Type _____ Dialysis Are you currently under the care of a nephrologist (YES) (NO)
DIABETES ?			Type 1 (Insulin dependent). Type 2 Pre-diabetes Years since diagnosis _____
THYROID problems ?			(Circle one). HYPERthyroid HYPOthyroid Number of years _____. Other _____
NEUROLOGIC problems ?			Headache. Migraine ADHD Seizures (frequency/duration)_____ TIA Stroke (when and deficit) _____ Cerebral Palsy Parkinson's Dementia Alzheimer's other_____
ORTHOPEDIC or **JOINT** Problems ?			Fractures (old) (new) where ?_____ Arthritis: Degenerative. Rheumatoid Osteoarthritis Neck problems TMJ Years _____ Joints affected _____
CHRONIC PAIN ?			Location of Pain _____ number of years _____. Do you take (NSAIDS) (Tylenol). (Narcotics) (Suboxone). Other therapy _____
Chronic or new **INFECTIONS** ?			Herpes Tuberculosis Hepatitis A, B or C HIV/AIDS other _____. Is infection active ? (yes) (no)
BLEEDING or **BLOOD** problems ?			Anemia Hemophilia (type)_____ Factor Deficiency (type)_____ Transfusion History (yes) (no) Sickle Cell Leukemia Blood Clots Other _____
ALCOHOL consumption ?			Frequency #_____ (drinks) per _____ Quit Alcohol _____
Any use of **CANNABIS** or "Street" Drugs ?			Cannabis Cocaine Methamphetamines Hallucinogens Narcotics Describe amount/frequency_____ Last time taken _____
CANCER ?			Type of cancer _____ year diagnosed _____ treatment: (Chemo) (Radiation) (Surgery) Status of treatment _____
Previous **ANESTHESIA i**ssues with you or family member ?			Please Describe : _____
Females only : Any chance of **PREGNANCY** ?			Date of Last Menstrual Period _____. If answer "no", Why ?_____
ANY OTHER MEDICAL ISSUE NOT COVERED			Please Describe any other medical issue

I verify that the information provided is complete, true and correct to the best of my knowledge. I authorize the release of this medical information to the Sandia Plastic Surgery staff, surgeons, anesthesia and facility providers.

Patient Signature. _____. Date ___ / ____ / ____