The Wall Center for Plastic Surgery
8600 Fern Avenue, Shreveport, LA 71105
Phone: 318.795.0801 Fax: 318.795.9492

Patient Medical and Personal History

Date:_____
Please answer all of the questions as accurately as possible. **This is a confidential record of your medical history and it will not be shared with anyone without your written permission.**

Name (Last, First):_____ **Age:**_____ **DOB:**_____

Height:_____ **Weight:**_____ What is the most you have ever weighed?_____

Do your scars or incisions normally heal well? ____ If no, explain: _____

Please list any and all surgeries and the dates they occurred. Be sure to include prior cosmetic surgeries and dates:
_____
_____
_____

Please list all past or current medical problems, hospitalizations, serious illnesses, accidents, serious injuries, broken bones and the dates they occurred (include any bleeding or clotting problems):
_____
_____
_____

List any medications or supplements you are taking:

Prescription	Non-prescription	Vitamins, Herbals, Supplements
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies _____

Other Allergies: ☐Iodine ☐Shellfish ☐Tape ☐Bandaids ☐Latex ☐Other

Smoking history? Yes☐ No☐ Quit-date _____
How many packs per day do you smoke, or did you smoke? _____ How many years? _____
Do you use any other products containing nicotine? _____ Type _____

Alcohol use: ☐Never ☐Monthly ☐Weekly ☐More than twice weekly ☐Daily

Do you, or have you ever used street drugs? ☐No If yes, which ones?_____

Please check: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Occupation _____ Highest Level of Education _____
Family Doctor _____ Date of Last Exam _____

Female History

Patient Name: _____

Number of pregnancies: _____ Number of deliveries:_____
Number of children breast fed:_____ Age of youngest child: _____
Date of last menstrual period: _____ Are you pregnant? _____
Are you considering having a child (or another child) in the future?_____

Date of last mammogram and results: _____
Do you have any breast pain? ____ Explain:_____

Have you ever had any breast lumps or breast problems?_____
_____
Do you have any blood relatives with breast cancer or disease? _____ If yes, which relatives? _____
_____

Complete following section only if considering breast surgery

Have you ever had breast surgery? _____ Describe surgeries and dates: _____
_____

What size bra do you wear now (34B)? _____ Do you wear a padded bra? _____
Largest size bra you have ever worn? _____ Do you always wear a bra? _____
Do you ever feel as though your breasts or your nipples droop too low? _____

Are your breasts uneven? _____ If so, explain: _____
_____

Do you wish to :

- ☐ be enlarged
- ☐ be reduced
- ☐ be enlarged and have position of nipple raised
- ☐ be reduced and have position of nipple raised
- ☐ stay almost the same size and have the position of nipple raised with skin tightened
- ☐ have older implants removed and replaced with new implants

Cosmetic surgery is an art more than a science, and bras vary in shape and size depending on the manufacturer, but in general, what size bra would you ideally like to be wearing?

Bra size and cup (example, 34D) _____

This best describes my wishes:

☐ I want a very full and rounded upper part of the breast. I want it to look like I have on a push-up bra all the time, even when I have nothing on (Think Victoria's Secret models).

☐ I want a full upper part of the breast, but I don't want it to bulge or appear rounded on top. I don't want it to look like I have a push-up bra on all the time.

☐ I would like something between the above two choices, with some upper breast roundness all the time, but only a small amount.

☐ Other: _____

Patient Name_____

PAST MEDICAL HISTORY: Have <u>YOU</u> ever had the following (Circle if YES):

☐Heart Disease	☐Arthritis	☐Rheumatic Fever
☐High Blood Pressure	☐Rheumatoid Arthritis	☐Tuberculosis
☐Diabetes	☐Cold Sores	☐Glaucoma
☐Bleeding Tendency	☐Fever Blisters	☐Hepatitis
☐Bleeding Problem	☐Shingles	☐Ulcer
☐Blood Clot	☐Genital Herpes	☐Thyroid Disease
☐Pulmonary Embolus	☐Pneumonia	☐Epilepsy
☐Cancer	☐Measles	☐Mumps
☐Stroke	☐Whooping Cough	☐Scarlet Fever
☐AIDS or HIV	☐Diptheria	☐Polio
☐Kidney Disease	☐Bronchitis	☐Venereal Disease
☐Mitral Valve Prolapse	☐Back/Neck Trouble	☐Low Blood Pressure
☐Migraine Headaches	☐Chickenpox	☐Mononucleosis
☐Fibromyalgia	☐Irritable Bowel Syndrome	☐Hernia
☐Transfusion	☐Hemorrhoids	☐Psoriasis
☐Asthma	☐High Cholesterol	☐Eczema
☐Multiple Sclerosis	☐Emphysema	

Any Other Diseases, please list_____

Date of Last Chest X-Ray_____ Date of Last Tetanus Shot_____

REVIEW OF SYSTEMS: Do <u>YOU</u> have now or have you had within the past year (Circle if YES):

☐Weight Change- Gained/Lost	☐Swollen Feet / Ankles	☐Seizures
☐Dry Eyes	☐Skin Rash	☐Joint or Muscle Pain
☐Chronic Cough	☐Chronic Diarrhea	☐Swollen Lymph Nodes
☐Chest Pain	☐Jaundice	☐Easy Bleeding
☐Rapid Heart Beat	☐Depression	☐Easy Bruising
☐Breast Pain	☐Breast Lump or Mass	☐Breast Discharge

FAMILY HISTORY:

	Present Age, or Age at Death	State of Health (good, fair, poor), or Cause of Death
Mother	_____	_____
Father	_____	_____
Brother(s)	_____	_____
Sister(s)	_____	_____
Children	_____	_____

Has any blood <u>relative</u> had any of the following (Circle if YES):

☐Bleeding Tendency	☐Stroke	☐Tuberculosis	☐Emphysema
☐Blood Clotting problem	☐Diabetes	☐Allergies	☐Epilepsy
☐Heart Disease	☐Anemia	☐Gout	☐Glaucoma
☐High Blood Pressure	☐Asthma	☐Leukemia	☐Kidney Disease
☐Drug / Alcohol Problem	☐Mental Illness	☐Depression	☐Obesity
☐Migraine Headaches	☐Thyroid Disease	☐Leukemia	☐Cancer

The Wall Center for Plastic Surgery
Reason for Visit

Patient Name:_____ Date:_____

What is the reason for today's visit?

_____
_____

Other procedures I would be interested in discussing in future visits:

_____ Breast Augmentation
_____ Breast Lift (Mastopexy)
_____ Breast Reduction
_____ Tummy Tuck (Abdominoplasty)
_____ Fat Injection
_____ Buttocks Augmentation
_____ Browlift
_____ Protruding Ears
_____ Liposuction/Body Contouring
_____ Eyelid Surgery (Blepharoplasty)
_____ Facelift / Neck Lift
_____ Nose Reshaping (Rhinoplasty)
_____ Lip Augmentation
_____ Chin Surgery
_____ Cheek Enhancement

Body Contouring after Weight Loss:

_____ Arm Lift (Brachioplasty
_____ Back Lift (Upper Body Lift)
_____ Thigh Lift
_____ Lower Body Lift

Jade Medispa Services:

_____ Fraxel Laser Skin Resurfacing
_____ Injectable Wrinkle Fillers (Juvederm, Radiesse, Sculptra, Restylane, etc.)
_____ Eyelash Lengthening
_____ Varicose Vein Treatments
_____ Laser Permanent Hair Reduction
_____ Chemical Peels
_____ Skin Texture/Complexion Analysis
_____ Botox
_____ Permanent Cosmetics
_____ UV Free Tanning
_____ Prescription Skin Care Products
_____ PhotoFacials (IPL)

How did you hear of us?_____

Whom can we thank for referring you?_____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I CONSENT TO THE PHOTOGRAPHS TAKEN TO BE USED FOR MEDICAL, SCIENTIFIC, OR EDUCATIONAL PURPOSES, PROVIDED MY IDENTITY IS NOT REVEALED BY THE PICTURES.

X_____ _____
Signature of patient (parent if minor) Date

THE WALL CENTER FOR PLASTIC SURGERY, L.L.C.

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SHREVEPORT, LA 71105

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Website: www.wallcenter.com Email: info@wallcenter.com

ACKNOWLEDGEMENT FORM

(Please Print Name)

I _____ have received the Notice of Privacy Practices and I have been provided the opportunity to review it.

Signature _____
Date _____

The Wall Center For Plastic Surgery

Dr. Simeon Wall, Sr. Dr. Holly Casey Wall Dr. Simeon Wall, Jr.

Date _____ Patient Name _____ SSN # _____
Male_____ Female_____ Age_____ DOB_____
Home Phone #_____ Cell Phone #_____ Email:_____
Address_____ City_____ State_____ Zip_____
Circle One: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or Parent's Employer_____Occupation_____Work #_____
Business Address_____City_____ State____ Zip_____
Spouse or Parent's Name_____ Employer_____Work #_____
Whom may we thank for referring you? _____
Person to contact in case of emergency? _____ Phone #_____

Responsible Party
Name of Person responsible for this account_____
Relationship to Patient_____ Home #_____ Cell #_____

Address_____
DOB_____ SSN #_____
Employer_____ Work #_____
Is this person currently a patient at our office? Yes☐ No☐

Please list the family members or other persons, if any, whom we may inform about your general medical condition and diagnosis (including treatment, payment and health care options).

Name_____ Relationship_____
Name_____ Relationship_____

Please print the address of where you would like your postcards and/or correspondence from our office to be sent if other than your home address.
_____
_____

Please indicate if you want all correspondence from our office marked "CONFIDENTIAL"

Yes☐ No☐

Please print the telephone # where you want to receive calls about your appointments, lab and x-ray results, and other health care information if other than your home #.
(_____)_____.

Can confidential messages be left on your answering machine? Yes☐ No☐

Patient/Guarantor Signature:_____
Date:_____

BUSINESS OFFICE POLICY

The primary goal of our physicians is the provision of quality patient care. This goal can be accomplished though sound fiscal management, the practice keeping costs contained, and having the cooperation of our patients implementing the following policies. Please review this document thoroughly and sign below. This will become part of your file.

COSMETIC SURGERY- Fees for cosmetic procedures are required in full, prior to the surgery date. This is payable in the form of cash, cashier's check, major credit cards or money order. If you wish to file a claim with your insurance carrier, we will provide you with the information needed for filing a claim.

INSURANCE CLAIMS- For those patients whose charges may be covered by insurance, our insurance department will be happy to file those charges and follow-up with your carrier. We ask that you provide our staff with all necessary information at the time of your first visit. Although we provide claim filing services as a courtesy to our patients, you will receive a monthly statement and be required to make monthly payments on your account until the balance is resolved. In the event your carrier refuses to issue benefits, we will be happy to negotiate a comfortable payment plan with you. Payments are required monthly on an outstanding balance. Your compliance is necessary to avoid collection referral from a source outside our office.

ASSISTANT SURGEON FEES- Your physician may elect to use the services of an assistant surgeon. Although his fee will appear on your monthly statement, you will be responsible for payment of this fee. This will be billed to your insurance carrier and assignment accepted.

MANAGED CARE NETWORKS- Our office participates in many managed care programs. If you are a member, you must provide the appropriate identification (insurance card). Co-payments and deductibles are due at the time of your visit. Our participation in these programs are subject to change.

MEDICARE/MEDICAID OR OUT OF NETWORK INSURANCE- Our physicians do not participate in the Medicare/Medicaid program. We will file all the necessary claims for you and payment from Medicare/Medicaid will be issued directly to you. You are responsible for payment of the services provided to you. If you have Blue Cross or United Healthcare you will be required to make monthly payments until the balance is paid. The insurance company will mail the check directly to your home. At this time you will be required to sign the back and mail it to our office so that appropriate write off's may be done.

The Wall Center for Plastic Surgery strives to provide excellent health care. We will only release information concerning you to those that are necessary and/or we have permission. Thank you for choosing our practice to provide you medical care. Please feel free to inquire about anything we can assist you with.

_____ _____

SIGNATURE DATE