Plastic & Aesthetic Surgical Associates

Patient Intake Form (page 2)

FAMILY HISTORY *(che*

DISEASE
High Blood Pressure
Heart Disease
Angina
Arrhythmia
Heart Attack
Asthma
COPD
High Cholesterol
Atrial Fibrillation
Stroke
Diabetes
Hepatitis
Bleeding Problems
Clotting Problems
Pulmonary Embolism
Emphysema

REVIEW OF SYSTEMS

Constitutional:
☐ Fever
☐ Chills
☐ Malaise
☐ Fatigue
☐ Anorexia

ENT:
☐ Sore Throat
☐ Scratchy Throat
☐ Hoarseness
☐ Nasal Congestion
☐ Nasal Discharge

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Patient Intake Form

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: ____
Preferred name to be addressed: _____ SSN: _____
Date of Birth: _____ Age: _____ Email Address: _____
Emergency Contact: _____ Relationship: _____ Phone #: _____

REFERRAL INFORMATION

Referring Physician: _____ Family Physician: _____
Other Physician(s) to notify? _____
Reason for Visit: _____

WHAT ARE YOUR MEDICAL PROBLEMS? *(i.e. high blood pressure, diabetes, heart conditions, stroke, etc.)*

WHAT SURGERIES HAVE YOU HAD?

What? Where? Type of Anesthesia

WHAT MEDICATIONS/HERBALS/VITAMINS DO YOU TAKE? *(Attach sheet if necessary with ALL listed info)*

Welcome!

We welcome you to Plastic & Aesthetic Surgical Associates. For your convenience, we are enclosing some forms that you will need to fill out prior to your examination. Please bring these completed with you to your appointment along with:

1) Photo ID
2) Insurance Cards
3) Your Co-Pay

If your insurance company requires a referral or pre-authorization before seeing a specialist, you will need to obtain that from your primary care physician. If your insurance company requires that you have a paper referral, please bring that along to your appointment. Without that referral you may need to reschedule your appointment. ***Please also be prepared to pay your co-pay at the time of check in.***

Additionally, if you've had any studies done pertaining to this visit (i.e. x-rays, blood work, pathology results), please let us know so that we may obtain all pertinent information prior to your office visit.

It is our policy that if you do not show for your appointment without prior notification, we reserve the right to charge you a $25.00 fee. Please also be aware that there will be a $35.00 service fee for any checks returned for insufficient funds.

If you have any questions, please don't hesitate to contact our office at (717) 625-3509.

We look forward to meeting with you!

Bryan J. Cicuto, D.O.

Plastic & Aesthetic Surgical Associates

Plastic & Aesthetic Surgical Associates

For more information about our practice please visit:
www.PlasticSurgeryInLancaster.com
www.facebook.com/PlasticSurgeryInLancaster
Phone: 717-625-3509 • Fax: 717-625-4258

First Name: _____ Email Address: _____ Relationship: _____ Family Physician: _____

Your scheduled appointment is on:

Appointment Date: _____

Appointment Time: _____

☐ Lititz Office ☐ Elizabethtown Office
Please arrive 15 minutes prior to your appointment.

If you are unable to keep your appointment, please give us 24 hours notification.

We want to give you our undivided attention for your appointment, so please make arrangements to leave children at home.

Plastic & Aesthetic Surgical Associates

OFFICE LOCATIONS
1535 Highlands Drive
Suite 300
Lititz, PA 17543

300 Continental Drive
Elizabethtown, PA 17022

Phone: 717-625-3509
Fax: 717-625-4258

FACIAL PROCEDURES
Brow Lift
Eyelid Surgery
Rhinoplasty (Nose) Surgery
Chin Augmentation
Neck Lift
Double Chin-Surgery
Face Lift
Cheek Lift
Ear Pinning (Otoplasty)

BODY PROCEDURES
Body Contouring Surgery
Liposuction, Abdominoplasty, Panniculectomy, Brachioplasty, Thigh Lift, Buttock Lift, Body Lift
C-Section Scar Revision
"Mommy Makeover"
(Tummy Tuck & Breast Surgery)
Rtrs Diasi Repair
Cool Sculpting

BREAST PROCEDURES
Breast Augmentation
Breast Lift (Mastopexy)
Breast Reduction

RECONSTRUCTION SURGERY

SKIN CARE
OBIGI Nu-Derm Products
Dermal Fillers
Botox
Photofacial IPL Photorejuvenation
Esthetician Services
Chemical Peels, Laser Hair Removal, Photodynamic Therapy

For a Complete Listing of all other services please visit:
www.PlasticSurgeryInLancaster.com

Plastic & Aesthetic Surgical Associates

Consultation Goals

PATIENT INFORMATIO

Name: _____
Preferred Name: _____
How did you hear abou

Please list the top 3 p
may list fewer).

1) _____
2) _____
3) _____

Please list the next 3

1) _____
2) _____
3) _____

What adjective(s) be

For example: Face:
Body:

Face: _____
Body: _____

How many years you

☐ 0-5 years

How much money d

☐ $0-$3,000

How much time off c

☐ 0-1 week

Plastic & Aesthetic Surgical Associates

Patient Profile Form

PATIENT INFORMATIO

Name: _____
Address: _____
City: _____
Age: _____ Sex: ☐ Fe
Do you currently have su
Do you sunburn easily?
What is your occupation
Do you participate in vig
Have you ever had a fa
Describe your reaction:
Are you facially post-op
Please list medications th
Are you allergic to: ☐ A
Do you have any seafoo
Any other allergies? _____
Describe your skin: _____
What about your skin bo
Do you consider your ski
Are you using Retin-A, A
Do you smoke? ☐ Yes

Plastic & Aesthetic Surgical Associates

Connect to Lancaster Medical Group
Patient Portal Access Form

Connect to Lancaster Medical Group is an easy way to go online to request prescription refills; ask your doctor questions; and see your medications, laboratory and radiology reports, vitals, allergies, diagnoses and procedures.

SIGN ME UP!

Patient Full Name: _____ Date of Birth: _____
(Print Please)
Email Address: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Patient's Signature (Patients 18 years or older): _____ Date: _____
(If patient is under 18 years only parent has to sign this form; if patient is 15-17 years both child and parent must sign)
Signature of Parent / Guardian (for patients under 18 years old): _____

YOU CAN ALSO DESIGNATE A RELATIVE, FRIEND OR CAREGIVER TO SEE YOUR INFO OR USE THE PORTAL ON YOUR BEHALF.

I also authorize the following person / people to access my Connect to Lancaster Medical Group patient portal:

Full Name: _____ Full Name: _____
(Print Please) *(Print Please)*
Relationship to Patient: _____ Relationship to Patient: _____
Email Address: _____ Email Address: _____
Mailing Address: _____ Mailing Address: _____
City / State: _____ City / State: _____
Zip Code: _____ Zip Code: _____
Phone Number: _____ Phone Number: _____

Patient Signature: _____ Date: _____
(Parent/Guardian if patient is under 18 years old)

Check off **one** category below

☐ **View Only Access:** allows person to see the patient's information.

☐ **Full Access:** allows person to see the patient's information, plus request prescription refills and ask questions of the patient's provider.

*Completed document should be scanned into Allscripts and placed under **Consents** with an internal note of Patient Portal User Agreement in Allscripts AMR.

POS Reorder # 1708456

Welcome To

Plastic & Aesthetic Surgical Associates

Skill and Precision in Plastic and Reconstructive Surgery