

STEFAN G. CHEVALIER, D.O., P.C.
Plastic and Reconstructive Surgery

Patient Information: Please print the following information CLEARLY and COMPLETELY.

Patient Name: _____
Last First Middle Initial

Address: _____
Street Address/Apt #/P.O. Box City State Zip Code

Home Phone: _____ Cell Phone: _____ Driver's license #: _____

Email: _____ Age: _____ Date of Birth: _____ Marital Status: S M W D Sex: M F

Employer/School: _____

Employer Address: _____

Work Phone: _____ ext: _____ Occupation: _____

Primary Care Physician: _____ Phone: _____

Who can we thank for referring you: _____

Please list the name of source

Please Fill Out Completely If Not The Same As Patient:

Primary Insurance: _____

Policy Holder: _____ Date of Birth: _____

Address: _____
(if different from above) Street Address/Apt, #/P. O. Box City State Zip Code

Home Phone#: _____ Work Phone#: _____

Employer: _____

Employer Address: _____

Insurance ID#: _____ Group#: _____

Secondary Insurance: _____

Policy Holder: _____ Date of Birth: _____

Address: _____
(if different from above) Street Address/Apt, #/P. O. Box City State Zip Code

Home Phone#: _____ Work Phone#: _____

Employer: _____

Employer Address: _____

Insurance ID#: _____ Group#: _____

If no insurance, person responsible for payment: _____

IN CASE OF EMERGENCY: (Name of relative/friend at a different address/number)

Name Relationship Phone (Home/Work/Cell)

Please Circle **Y** to the ones that apply to you and **N** for the ones that do not apply:

Medical History: Smoker	y/n	Alcohol daily	y/n
Seizures	y/n	Diabetes	y/n
Heart Trouble	y/n	Thyroid disease	y/n
High Blood Pressure	y/n	Asthma	y/n
Liver Disease	y/n	Tuberculosis	y/n
Kidney Disease	y/n	Shortness of breath	y/n
Bleeding problems	y/n	Stroke	y/n
Aspirin use	y/n	Sleep apnea	y/n

Please completely fill out: (Write N/A for any that do not apply):

Family Medical History: _____
(Immediate family: mother/father)

Medical Conditions: (Please list any significant medical conditions that you **(Patient)** have)

Operations: (Please list all operations that you **(Patient)** have had): _____

Current Prescribed Medications **(Patient)**:

Allergies **(Patient)**: _____

Please describe in detail the reason for your visit: _____

I authorize and request my insurance company to pay Dr. Stefan G. Chevalier directly any insurance benefits otherwise payable to me. I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered during the period of such care to third party payers and/or other health care practitioners. I understand that I am financially responsible for all changes not paid for by insurance. I, hereby, authorize Dr. Stefan G. Chevalier to take photographs, slides, and/or videotapes appropriate for my condition/surgery. I further authorize Dr. Stefan G. Chevalier to the use the photographs, slides, and/or videotapes for professional medical purposes deemed appropriate, including but not limited to showing the photographs, slides, and/or videotapes for purposes of medical entitled to any payment or other forms of remuneration as a result of any use of the photographs, slides, and/or videotapes of my condition/surgery and/or the interview concerning the condition/surgery.

Patient Signature: _____ Date: _____

Signature of parent/legal guardian (if a minor): _____ Relationship: _____