STEPHEN X. GIUNTA, M.D., F.I.C.S.
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NEW PATIENT INFORMATION

NAME ______________________ ______________________
(Last) (First)

ADDRESS ______________________ ______________________
(Street) (City)

______________________ ______________________
(State) (Zip Code)

BIRTHDATE ______________________ **AGE** ______________________

HOME PHONE ______________________ **Email address:** ______________________

EMPLOYER ______________________ **WORK PHONE** ______________________

HOW LONG EMPLOYED THERE ______________________

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

Name: ______________________

Relationship: ______________________

Phone Number: ______________________

REFERRED BY ______________________

FAMILY DOCTOR ______________________

INSURANCE

POLICY HOLDER ______________________ **INSURANCE CO** ______________________

IDENTIFICATION NUMBER ______________________ **EFFECTIVE DATE** ______________________

SECONDARY INSURANCE ______________________

I hearby authorize Stephen X. Giunta, M.D. to furnish information to my insurance carriers concerning my illness and treatment (s) and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for all charges incurred by myself or my dependents.

______________________ ______________________
(Signature) (Date)

MEDICAL HISTORY

Please Check Yes or No		**YES**	**NO**
1.	Have you had any previous surgery? If yes, please list with dates:	________	________
2.	Do you have any allergies? If yes, please list:	________	________
3.	Are you currently taking medications? If yes, please list (including aspirin, birth control pills, accutane, vitamins, etc.):	________	________
4.	Do you smoke? If yes, list how often and how much:	________	________
5.	Do you drink alcohol? If yes, how often:	________	________
6.	Have you ever had a history of facial numbness or weakness?	________	________
7.	Have you ever had Bell's Palsy?	________	________
8.	Have you ever had a cold sore?	________	________
9.	Have you ever had a herpes out-break?	________	________
10.	Are you pregnant?	________	________
11.	Are you at risk for AIDS?	________	________
12.	Have you ever had an AIDS test?	________	________
13.	Do you have high blood pressure?	________	________
14.	Do you have a history of poor healing? (i.e. keloids, diabetes, etc.)?	________	________
15.	Do you have a bleeding disorder?	________	________
16.	Do you have varicose veins?	________	________
17.	Have you ever had phlebitis?	________	________
18.	Have you recently had a weight loss or gain (over 10 lbs.)?	________	________
19.	Have you ever had hepatitis or jaundice?	________	________
20.	Do you have any eye problems? If yes, please list:	________	________
21.	Have you ever had any problems with local anesthesia? If yes, please list:	________	________
22.	Have you ever had any problems with general anesthesia?	________	________
23.	Has any member of your family ever had a problem with local or general anesthesia? If yes, please list:	________	________
24.	Is there any medical condition that you have that I should know about (other than listed above)? If yes, please list:	________	________

Please fill out the best of your knowledge. This is a confidential record of your medical history and will be kept in your chart. No information will be released without your permission.

I. MEDICAL HISTORY: If you have or have had any of the following, please mark with an (X):

_____Cold Sore	_____Pneumonia	_____Rheumatic Fever
_____Herpes	_____Pleurisy	_____Nervous Breakdown
_____Ulcers	_____Tuberculosis	_____Venereal Disease
_____Cancer	_____Diabetes	_____High Blood Pressure
_____Convulsions	_____Arthritis	_____Depression
_____Angina (Chest Pain)	_____Hepatitis	_____Heart Disease
_____HIV/Positive	_____Anemia	_____Facial Numbness or Weakness
_____Aids	_____Jaundice	

HEAD	**EENT**	**RESPIRATORY**
_____Headaches	_____Impaired Hearing	_____Chronic Cough
_____Dizziness	_____Double Vision	_____Bloody Sputum
_____Tremors	_____Poor Vision	_____Night Sweats
_____Fainting	_____Nasal Obstruction	_____Chest Pains
	_____Sinus Infection	_____Weight Loss
	_____Post Nasal Drip	_____Wheezing

CARDIOVASCULAR	**NEUROMUSCULAR**	**GASTRO INTESTINAL**
_____Chest Pain	_____Seizures	_____Nausea/Vomiting
_____Heart Attack	_____ Loss Equilibrium	_____Lack of Appetite
_____Shortness of Breath	_____ Loss of Consciousness	_____Difficulty Swallowing
_____Palpitations	_____ Joint Disorders	_____Chronic Indigestion
_____Irregular Heartbeat	_____ Numbness	_____Black Stool/Bleeding
_____Bleeding Tenderness	_____ Paralysis	_____Hemorrhoids
_____Varicose Veins	_____ Pain	_____Ulcer History

GENITO-URINARY

_____Blood in Urine
_____Backache
_____Discharge
_____Difficulty in Urination

II. PAST MEDICAL HISTORY/OPERATIONS:____
____
____

III. Have you ever had difficulties with Local Anesthesia? ___________ **General?**_____________________
Has any member of your family had problems with Local or General Anesthesia? _______________
If YES, please explain: ____

IV. Is there a history of Cancer in your family? ______________
If YES, relation and type of Cancer ____

SOCIAL HISTORY:

Approximate daily consumption of:

Alcohol: ___________________ Tobacco: ___________________ Coffee: _____________________

Recreational Drugs: _______________________

RECENT EXAMINATIONS:

History & Physical	__________ YES	__________ NO	Date __________
Chest X-ray	__________ YES	__________ NO	Date __________
EKG	__________ YES	__________ NO	Date __________
Lab, Blood Work	__________ YES	__________ NO	Date __________

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

Name: ____

Relationship: ____

Phone Number: ____

IS THERE ANY MEDICAL CONDITION THAT YOU HAVE THAT I SHOULD KNOW ABOUT (OTHER THAN LISTED ABOVE)? IF YES, PLEASE LIST ___________________________________

____

____

____ ____

Patients Signature **Date**

I HAVE BEEN GIVEN A COPY OF AESTHETIC PLASTIC SURGERY'S NOTICE OF PRIVACY INFORMATION

____ ____

Patients Signature **Date**