J. MARTIN ENGLISH, M.D., P.A.

PATIENT REGISTRATION INFORMATION

If patient cannot be billed for these services (for example minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Name: _____ (LAST) _____ (FIRST) ___ (MI) ___ (SEX) ___/___/___ (DATE OF BIRTH) S M D W O (MARITAL STATUS)

Address: _____ (STREET/P.O. BOX) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

Contact Information: _____ (HOME PHONE) _____ (WORK PHONE) _____ (CELL/ALT. PHONE)

Social Security #: _____ Email Address: _____

Employment Status: Full Time Part Time Retired Unemployed Student
PLEASE CIRCLE ONE

Employer Information: _____ (NAME) _____ (OCCUPATION/TITLE)

_____ (STREET/P.O. BOX) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

Emergency Contact: (Please indicate a friend or relative not living at the same address):

_____ (NAME) _____ (PRIMARY PHONE) _____ (ALT. PHONE) _____ (RELATIONSHIP)

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor or guardian.

Patient relationship to Responsible Party: ☐ Child ☐ Other (please specify): _____

Name: _____ (LAST) _____ (FIRST) ___ (MI) ___ (SEX) ___/___/___ (DATE OF BIRTH) S M D W O (MARITAL STATUS)

Address: _____ (STREET/P.O. BOX) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

Employment Status: Full Time Part Time Retired Unemployed Student
PLEASE CIRCLE ONE

Employer Information: _____ (NAME) _____ (OCCUPATION/TITLE)

_____ (STREET/P.O. BOX) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

PRIMARY INSURANCE

Please provide copy of card to our office to attach to this form

Insurance Company: _____ HMO PPO POS Phone Number: _____

Address: _____ (STREET/P.O. BOX) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

Policy Holder: _____ (LAST) _____ (FIRST) ___ (MI) ___ (SEX) ___/___/___ (DATE OF BIRTH) _____ (SS#)

Patient Relationship to Insured Party: ☐ Self ☐ Spouse ☐ Child ☐ Other (specify): _____

Employer's Name: _____ ID #: _____ Group: _____

SECONDARY INSURANCE

Please provide copy of card to our office to attach to this form

Insurance Company: _____ HMO PPO POS Phone Number: _____

Address: _____ (STREET/P.O. BOX) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

Policy Holder: _____ (LAST) _____ (FIRST) ___ (MI) ___ (SEX) ___/___/___ (DATE OF BIRTH) _____ (SS#)

Patient Relationship to Insured Party: ☐ Self ☐ Spouse ☐ Child ☐ Other (specify): _____

Employer's Name: _____ ID #: _____ Group: _____

REFERRAL INFORMATION

☐ Personal Reference _____ ☐ Physician Referral _____

Patient Signature: _____ **Date:** _____

PHYSICIAN / PHARMACY INFORMATION

	NAME	PHONE	FAX
Primary Care Physican			
Dermatologist			
Moh's Surgeon			
Cardiologist			
Oncologist			
OB/GYN			
Other			

PHARMACY

Name: _____ City: _____

Phone: _____ Fax: _____

PATIENT NAME: _____
DATE OF BIRTH: _____

MEDICAL / SURGICAL HISTORY

DRUG ALLERGIES

☐ NO KNOWN DRUG ALLERGIES

List all medications to which you are allergic and the reaction.

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

CURRENT MEDICATIONS

Please list all medications, vitamins and herbs you are currently taking.

(1) _____ (Mg) _____ Frequency: _____ Reason: _____

(2) _____ (Mg) _____ Frequency: _____ Reason: _____

(3) _____ (Mg) _____ Frequency: _____ Reason: _____

(4) _____ (Mg) _____ Frequency: _____ Reason: _____

(5) _____ (Mg) _____ Frequency: _____ Reason: _____

(6) _____ (Mg) _____ Frequency: _____ Reason: _____

ASPIRIN and IBUPROFEN

Do you use aspirin, aspirin containing products or ibuprofen? No Yes If so, how much/often?_____

Do you use any other drugs or medications, legal or otherwise? If so, please discuss confidentially with the surgeon.

PAST MEDICAL HISTORY

Do you have or have you previously had any of the following?

Stroke	No	Yes	Cancer	No	Yes
Diabetes	No	Yes	Bleeding Tendency	No	Yes
High Blood Pressure	No	Yes	Stomach Ulcer	No	Yes
Heart Disease	No	Yes	Back Problems	No	Yes
Heart Attack	No	Yes	Hepatitis	No	Yes
Lung Disease	No	Yes	Leukemia	No	Yes
Bronchitis	No	Yes	Psychiatric	No	Yes
Pneumonia	No	Yes	Thyroid Disease	No	Yes
Tuberculosis	No	Yes	Kidney Disease	No	Yes
Other	Explain: _____				

Have you ever had a blood transfusion? No Yes _____

Have you ever taken steroids? No Yes _____

Do you have a history of anesthesia reactions? No Yes _____

Do you have any tattoos? No Yes If so, date of tattoos: _____

Serious injuries or accidents: _____

FAMILY HISTORY

Breast Cancer No Yes Pneumonia No Yes Heart Attacks No Yes

PATIENT NAME: _____ DATE OF BIRTH: _____

DATE: _____

MEDICAL / SURGICAL HISTORY

SOCIAL HISTORY

TOBACCO

Do you smoke? No Yes - _____ packs per day How many years? _____

If no longer smoking, for how long? _____ years

Do you use any tobacco products or nicotine substitute? No Yes - _____

ALCOHOL

Do you drink alcohol? No Yes How much? _____

SURGICAL HISTORY

Starting with the most recent, list all surgeries, be sure to include all cosmetic procedures (exclude minor procedures).

Year: _____ Procedure: _____

Surgeon (First & Last Name): _____

Year: _____ Procedure: _____

Surgeon (First & Last Name): _____

Year: _____ Procedure: _____

Surgeon (First & Last Name): _____

Year: _____ Procedure: _____

Surgeon (First & Last Name): _____

Year: _____ Procedure: _____

Surgeon (First & Last Name): _____

Year: _____ Procedure: _____

Surgeon (First & Last Name): _____

_____

IS THERE ANYTHING ELSE YOU FEEL THE SURGEON SHOULD KNOW ABOUT YOUR MEDICAL HISTORY OR CURRENT CONDITION? No Yes - _____

_____

OFFICE USE ONLY

_____

_____

MRSA QUESTIONAIRE
(Methicillin-resistant Staphylococcus Aureus)

1. In the past 6 months have you spent more than 4 days in a hospital or long term facility? Yes _____ No _____

2. Do you have a current skin or soft tissue infection? Yes _____ No _____

3. Have you had a previous history of MRSA colonization or infection?
   Yes _____ No _____

_____
Signature of Patient or Authorized Representative

_____
Date

Supply Fees for Office Surgery

If you require office surgery, there will be a separate associated fee for the supplies necessary to perform the procedure(s), even if insurance is billed for the procedure. Insurance will not reimburse physicians for their supply costs.

As such, we require payment of $50-$75 for a sterile tray and the suture material or other supplies necessary to provide you our best care. Your insurance will not be billed for these supply costs.

_____

Patient Signature

_____

Date

J. Martin English MD, PA
plastic surgery

Patient Photograph Consent

I ☐ do ☐ do not authorize J. Martin English, M.D. to take photographs of me and to use them as aid in my treatment. I understand these photographs will become part of my permanent record.

In an effort to give potential and new patients a better understanding of the results that can be achieved, we often use visual aids such as the photographs that were taken of your particular case which could be used on our website or in our photo book. If you allow them to be shared with others who have the same or similar procedure, please understand that your photographs never show faces unless, of course, the face is involved. If your photographs are used on our website, they will be accessible for viewing on the internet.

I ☐ will allow my photographs to be shared with others.

I ☐ will not allow my photographs to be shared with others.

Signature: _____ **Date:** _____

Ft. Worth
1325 Pennsylvania Ave. Suite 325
Fort Worth, Texas 76104

Plano
6020 W. Parker Rd., Suite 450
Plano, Texas 75093

214-368-8844 • Fax 214.368.3472
www.docenglish.com

J. Martin English MD, PA
plastic surgery

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

SSN: _____ Any previous name(s): _____

I request and authorize _____ to release the medical records of the patient named above to:
Name of Clinic/Practice

J. Martin English, M.D., PA
6020 W. Parker Rd., Suite 450
Plano, Texas 75093
Office: 214-368-8844 FAX: 214-368-3472

This request and authorization applies to:

_____ Health care information relating to the following treatment, condition or dates of treatment:

_____

_____ All health care information.

_____ Other: _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

_____ _____
Signature of Patient or Patient's Authorized Representative Date signed

_____
Relationship or status if signed by anyone other than patient
(parent, legal guardian, personal representative, etc.)

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED

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