MICHAEL J. SUNDINE, M.D., F.A.C.S., F.A.A.P.
Board Certified Plastic Surgeon
Facial Aesthetic-Cosmetic-Craniofacial Surgeon-Reconstructive-Pediatric Plastic Surgery

Reason for Consultation _____ Date _____
(Facelift, Brow/Forehead Lift, Eyes, Nose, Breast Augmentation, etc. Nevus Cleft Lip-Otoplasty-Hemangioma-Craniofacial)

Patient Information

Primary Language_____ Do you need a translator _____yes _____no

Name _____ Date of Birth _____ Age _____
Mr. Mrs. Ms. Miss Dr.

Address _____ Home # ( ) _____

City _____ State _____ Zip _____ Cell # ( ) _____

E-Mail Address_____ Voicemail ( ) _____

May we email you updates or specials? Yes___No_____

May we leave a voicemail message ___yes _____no

May we text you appointment reminders ___yes ___no

Number to text to:_____

Responsible Party/Parent/Guardian: Employment Information (Responsible Person Employment Information)

Parent/Guardian/Responsible Party Name:_____

Phone:_____

Address (if different from above:)_____

City_____State_____Zip_____

Employed by _____ Work # ( ) _____

Business Address _____

City _____ State _____ Zip _____

Marital Status ☐ Married___ ☐ Single___

Name _____ Cell # ( ) _____

Employed by _____ Work # ( ) _____

Business Address _____

City _____ State _____ Zip _____

Name and Address of Nearest Relative Not Living with You

Name _____ Relationship _____
Mr. Mrs. Ms. Miss Dr.

Address _____ Phone # ( ) _____

City _____ State _____ Zip _____

Referral Information May we contact? ❒ Yes ❒ No

Referred by _____ Phone # ( ) _____

Address _____

City _____ State _____ Zip _____

PATIENT/GUARDIAN INITIALS_____

FOR INSURANCE CASES ONLY:

SUBSCRIBER NAME: _____

INSURANCE: IF YOU HAVE AND ID CARD FOR INSURANCE, PLEASE HAND IT TO THE RECEPTONIST TO COPY

Name of Insurance Company _____ Phone ( ) _____

Address _____ City, State _____

Zip _____ ID Information (Policy #, Group #, etc.) _____

Secondary Insurance _____

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ALL OF MY MEDICAL BILLS INCURRED, NOT MY INSURANCE COMPANY OR OTHER THIRD PARTY. ANY BALANCE THAT IS NOT COVERED BY INSURANCE (FOR INSURANCE CASES) WILL BE MY RESPONSIBILITY. I UNDERSTAND THAT DR. SUNDINE MAY NOT BE CONTRACTED BY INSURANCE CARRIER, AND HAVE BEEN INFORMED SO BY DR. SUNDINE OFFICE STAFF, PRIOR TO AND OR AT MY CONSULTATION. I UNDERSTAND THAT DR. SUNDINE OR HIS STAFF HAVE NO RESPONSIBILITY OR CONTORL OF WHAT MY INSURANCE COMPANY REIMBURSES, AND I WILL NEED TO SEEK OUT MY CUSTOMER SERVICE REPRESENTATIVE WITH MY INSURANCE COMPANY PRIOR TO ANY ENCOUNTERS, APPOINTMENTS, OR SERVICES TO HAVE EXPLAINED TO MY INSURANCE BENEFITS, AND MAKE SURE ANY AND ALL AUTHORIZATIONS ARE IN PLACE PRIOR TO ANY SERVICES PROIVDED BY DR. SUNDINE OR HIS ASSOCIATES. I HEREBY AUTHORIZE MICHAEL J. SUNDINE, M.D. TO FURNISH INFORMATION TO INSURANCE CARRIERS OR OTHER THIRD PARTIES: CONCERNING THIS ILLNESS. I HEREBY IRREVOCABLY ASSIGN TO MICHAEL J. SUNDINE, M.D. ALL PAYMENTS FOR MEDICAL SERVICE RENDERED BY MICHAEL J SUNDINE MD. Inc.. I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ Date _____

Signature of Financially Responsible Person

Primary Care Doctor _____ Phone # ( ) _____

His/Her Address _____

City _____ State _____ Zip _____

Present Illness:

Description _____

Onset _____

Severity of the problem (Scale of 1-10) _____

Location initially, Sites of recurrence _____

Symptoms, preceding and associated _____

How long has the problem lasted? _____

Previous therapy _____

Past History:

Do you have any chronic medical problems?

☐ Hypertension	☐ Diabetes Mellitus	☐ Cancer
☐ Heart Disease	☐ Kidney Disease	☐ HIV or AIDS
☐ Heart Failure	☐ Seizures	☐ Bleeding Problems
☐ Heart Attack	☐ Liver Disease	☐ Stroke
☐ Emphysema	☐ Hepatitis	☐ Ulcers
☐ Asthma	☐ High Cholesterol	☐ Sleep Apnea
☐ Deep Venous Thrombosis	☐ Pulmonary Embolism	☐ Other _____

PATIENT/GUARDIAN INITIALS_____

Please list all prior operations:	**Date**	**List any complications**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Please list ALL medications you are taking, include over the counter medications (eg. Aspirin, Motrin, etc.), vitamins, and herbal remedies (Echinacea, Fish Oil, etc.).

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

List any allergies to medications and describe the reactions.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Family History-Do you have any family history of medical problems?

- ☐ Hypertension
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Heart Attack
- ☐ Emphysema
- ☐ Diabetes Mellitus
- ☐ Kidney Disease
- ☐ Seizures
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Cancer
- ☐ HIV or AIDS
- ☐ Bleeding Problems
- ☐ Stroke
- ☐ Other _____

Social History-

Have you ever smoked cigarettes? _____ Yes _____ No. If yes, please state the year started _____

How many packs per day did (do) you smoke? _____

If you are a former smoker, state the year you stopped _____

Alcohol Consumption: Never _____ Rare _____ Moderate _____ Heavy _____

Did you ever drink heavily in the past? Yes _____ No _____

Do you ever use drugs? Yes _____ No _____ Type _____ Frequency _____

Occupation _____ Marital Status _____

Height: _____ Weight_____

PATIENT/GUARDIAN INITIALS_____

Review of Systems: Do you have any of the following conditions, illnesses, or symptoms?

General

- ☐ Chills
- ☐ Fevers
- ☐ Loss of sleep
- ☐ Weight loss
- ☐ Sweats

Eye, Ear, Nose, and Throat

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hayfever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems ☐ Vision-flashes, halos

Cardiovascular

- ☐ High blood pressure
- ☐ Heart attack
- ☐ Angina/chest pain
- ☐ Irregular heart beat
- ☐ Heart murmur
- ☐ Heart failure
- ☐ Pacemaker
- ☐ Swelling of ankles
- ☐ Varicose veins

Respiratory

- ☐ Abnormal chest x-ray
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Recent chest infection
- ☐ Shortness of breath
- ☐ Shortness of breath at night
- ☐ Shortness of breath on exertion
- ☐ Cough
- ☐ Cough
- ☐ Cough with sputum
- ☐ History of tuberculosis

Gastrointestinal

- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hiatal hernia
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Ulcers
- ☐ Vomiting
- ☐ Vomiting blood

Genitourinary

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ History of kidney disease
- ☐ History of urinary disease

Musculoskeletal

- ☐ Arthritis
- ☐ Rheumatoid arthritis
- ☐ Herniated disc
- ☐ Sciatica
- ☐ Neck problems
- ☐ Back problems
- ☐ Leg problems
- ☐ Arm problems

Endocrine

- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Taken steroids

Hematologic/Oncologic/Infectious

- ☐ Bleeding tendency
- ☐ Easy bruising
- ☐ Anemia
- ☐ Sickle cell disease
- ☐ Blood clots in legs
- ☐ Blood clots in lungs
- ☐ Radiation therapy

Skin

- ☐ Hives
- ☐ Itching
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Sores that won't heal

Neuropsychiatry

- ☐ Stroke
- ☐ Seizures
- ☐ Fainting
- ☐ Dizziness
- ☐ Headaches
- ☐ Depression
- ☐ Anxiety
- ☐ Psychiatric care
- ☐ Forgetfulness
- ☐ Nervousness
- ☐ Numbness

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other _____

WOMEN only

- ☐ Abnormal Pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other _____

Date of last menstrual period _____

Number of pregnancies _____

Number of children _____

Did you breast feed? _____

Could you be pregnant? _____

Date of last mammogram _____

Date of last Pap smear _____

MEDICAL DOCTORS ARE LICENSED AND REGULATED BY
THE MEDICAL BOARD OF CALIFORNIA
1-800-633-2322
www.mbv.ca.gov

PATIENT/GUARDIAN
SIGNATURE_____DATE_____