

NAME: FIRST

MIDDLE

LAST

TODAY'S DATE

FACIAL COSMETIC SURGERY

- DROOPING EYELIDS
- LOWER EYELIDS
- UPPER EYELIDS
- FOREHEAD LIFT
- CHIN ENHANCEMENT
- CHEEK ENHANCEMENT
- LIP CONTOURING
- FAT INJECTIONS
- DROOPING BROWS
- NECK / FACELIFT
- FACIAL FULLNESS / DROOPING

COSMETIC EAR SURGERY

- OTOPLASTY (EAR PINNING)
- EAR LOBE REDUCTION
- REPAIR TORN EARLOBE

COSMETIC NASAL SURGERY

- NASAL SURGERY
- CORRECTION OF OBSTRUCTED BREATHING
- COSMETIC SURGERY TO CHANGE APPEARANCE

BREAST SURGERY

- BREAST ENLARGEMENT
- BREAST REDUCTION (MALE OR FEMALE)
- BREAST LIFT
- TREATMENT OF BREAST ASYMMETRY
- POST-MASTECTOMY RECONSTRUCTION
- TREATMENT OF BREAST ASSYMMETRY

BODY CONTOURING

SUCTION-ASSISTED LIPECTOMY:

- NECK
- CHIN
- THIGHS
- ABDOMEN
- KNEES
- HIPS
- CALVES
- ARMS
- ABDOMINOPLASTY (TUMMY TUCK)
- AFTER MAJOR WEIGHT LOSS
- ARM LIFT
- BUTTOCK LIFT
- THIGH LIFT

VIORA:

- FACIAL OR NECK TIGHTENING
- JOWLS OR CHIN TIGHTENING
- CELLULITE TREATMENT
- CIRCUMFRENENTIAL REDUCTION

FACIAL SKIN RENEWAL

- SKIN CARE ADVICE & PRODUCTS
- TIRED-LOOKING SKIN
- CHEMICAL PEELS
- MICRODERMABRASION
- UNEVEN SKIN TONE
- BROWN / AGE SPOTS / FRECKLES
- ROUGH SKIN TEXTURE
- DERMAL FILLERS: RESTYLANE, JUVEDERM
- THIN LIPS
- HANDS: AGE SPOTS, ETC.
- UNWANTED HAIR
- LONGER, THICKER, DARKER LASHES
- ACNE TREATMENTS
- BOTOX INJECTIONS
- SCARRING/FACIAL SCARRING
- LASER SKIN TREATMENTS FOR FINE LINES / WRINKLES
- ROSACEA TREATMENTS / FACIAL REDNESS
- ACNE SCAR TREATMENT
- PELLEVE

OTHER

- VEIN TREATMENT
- SCAR IMPROVEMENT
- LASER HAIR REMOVAL
- MOLE OR LESION REMOVAL
- LASER NAIL FUNGUS REMOVAL
- OTHER: _____

GENDER:

- MALE
- FEMALE

AGE: _____ ZIP CODE: _____

CLINIC LOCATION:

- EAU CLAIRE
- RIVER FALLS

WHO ARE YOU SEEING TODAY?

- DR. RUCKER
- OTHER _____

PLEASE TELL US HOW YOU FIRST HEARD ABOUT OUR CLINIC?

- FRIEND
 - INTERNET
 - PROFILES MAGAZINE
 - DOCTOR REFERRAL
 - PRINT AD
 - OTHER:
- _____
- _____

WHAT PROMPTED YOU TO MAKE THIS APPOINTMENT?

NAME: FIRST _____ MIDDLE _____ LAST _____ DATE OF BIRTH _____ TODAY'S DATE _____

PERSONAL HISTORY:	YES	NO	REMARKS
TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	_____
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART CONDITION	<input type="checkbox"/>	<input type="checkbox"/>	_____
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	_____
ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	_____
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	_____
EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>	_____
NERVOUS DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	_____
ASTHMA / HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>	_____
PACEMAKER / ICD	<input type="checkbox"/>	<input type="checkbox"/>	_____
IMPLANTS	<input type="checkbox"/>	<input type="checkbox"/>	_____
INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>	_____
BLEEDING HISTORY	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	_____
BLOOD PRESSURE	HIGH <input type="checkbox"/>	LOW <input type="checkbox"/>	NORMAL <input type="checkbox"/>
OTHER DISEASES	_____		

PERSONAL OR FAMILY HISTORY	YES	NO
MALIGNANT HYPERTHERMIA	<input type="checkbox"/>	<input type="checkbox"/>
UNEXPECTED DEATH	<input type="checkbox"/>	<input type="checkbox"/>
SINUSITIS	<input type="checkbox"/>	<input type="checkbox"/>
NEUROMUSCULAR DISORDER	<input type="checkbox"/>	<input type="checkbox"/>
UNANTICIPATED FEVER FOLLOWING GENERAL ANESTHESIA	<input type="checkbox"/>	<input type="checkbox"/>

ALLERGIES & SENSITIVITIES:	YES	NO	REMARKS
PENICILLIN	<input type="checkbox"/>	<input type="checkbox"/>	_____
SULFA DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER ANTIBIOTICS	<input type="checkbox"/>	<input type="checkbox"/>	_____
ASPIRIN	<input type="checkbox"/>	<input type="checkbox"/>	_____
CODEINE	<input type="checkbox"/>	<input type="checkbox"/>	_____
PERCOCET	<input type="checkbox"/>	<input type="checkbox"/>	_____
VICODIN	<input type="checkbox"/>	<input type="checkbox"/>	_____
ANESTHETICS	<input type="checkbox"/>	<input type="checkbox"/>	_____
ADHESIVE TAPES	<input type="checkbox"/>	<input type="checkbox"/>	_____
LATEX	<input type="checkbox"/>	<input type="checkbox"/>	_____
FOODS	_____		

PREVIOUS SURGERIES AND DATES: _____

HAVE YOU HAD ANY COSMETIC SURGERY? YES NO
 IF YES, PLEASE SPECIFY: _____

NO. OF PREGNANCIES: _____ NO. OF CHILDREN: _____

LAST MENSTRUAL PERIOD: _____

CURRENT MEDICATIONS AND VITAMINS: _____

LAST PHYSICAL CHECKUP: _____

GENERAL HEALTH: _____

DO YOU TAKE COUMADIN / WARFARIN/PLAVIX? YES NO

DO YOU SMOKE? YES, HOW MUCH: _____ NO

CONSUME ALCOHOL? YES, HOW MUCH: _____ NO

HAVE YOU EVER CONSULTED A PSYCHIATRIST? YES NO

ARE YOU CURRENTLY SEEING A PSYCHIATRIST? YES NO

IF YES, PSYCHIATRIST'S NAME, ADDRESS & PHONE _____

HEIGHT _____ WEIGHT _____

RUCKER MD PLASTIC SURGERY CLINIC

JOSEPH W. RUCKER, MD, FACS

PATIENT INFORMATION

This record will become part of your permanent file.

Please write legibly and complete both sides.

M F

NAME: FIRST MIDDLE LAST DATE OF BIRTH AGE SOC SEC. #

ADDRESS CITY STATE ZIP HOME PH. CELL PH.

SINGLE MARRIED WIDOWED DIVORCED FULL TIME STUDENT

EMPLOYER / SCHOOL: NAME & ADDRESS PHONE

NAME OF SPOUSE / PARENT (IF UNDER 18): SPOUSE / PARENT'S EMPLOYER NAME & ADDRESS PHONE

FAMILY DOCTOR: NAME & ADDRESS PHONE

REFERRED BY: YOUR DOCTOR'S NAME & ADDRESS PHONE

OR REFERRED BY (PLEASE SPECIFY): FRIEND YELLOW PAGES WEBSITE PROFILES OTHER

PRIMARY INSURANCE NAME SUBSCRIBER NAME SUBSCRIBER DOB SUBSCRIBER SS#

SUBSCRIBER NO. GROUP NO. GROUP NAME

REASON FOR VISIT:

IF DUE TO INJURY: DATE OF INJURY WHERE INJURY HAPPENED HOW INJURY HAPPENED

WORK RELATED YES NO EMPLOYER'S ADDRESS COMP. CARRIER CLAIM NO.

Put me on your office informational MAILING LIST: YES NO EMAIL ADDRESS _____

I authorize release of any medical information which may be requested by my insurance company concerning my present illness or injury. I authorize payment of any medical benefits to which I am entitled for services provided by Rucker MD Plastic Surgery Clinic. I understand that I am financially responsible for any charges not paid by my insurance company. I understand no claims will be filed with my insurance carrier/Medicare/Medicaid for cosmetic procedures and that I am responsible for any costs associated with consultation or surgery.

I acknowledge that I have received written Notice of Privacy Practices from Rucker MD Plastic Surgery Clinic.

THE PATIENT'S CONDITION PROHIBITS THE INDIVIDUAL FROM SIGNING AN ACKNOWLEDGEMENT AT THIS TIME. IT WILL BE OBTAINED AS REASONABLY PRACTICABLE AFTER THE PATIENT'S CONDITION IMPROVES.

ACKNOWLEDGEMENT WAS UNABLE TO BE OBTAINED. REASON _____

PATIENT OR PERSONAL REPRESENTATIVE

DATE