

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

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.

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

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: \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

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 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

NAME: FIRST

MIDDLE

LAST

TODAY'S DATE

### BREAST SURGERY

- BREAST AUGMENTATION (ENLARGEMENT)
- MASTOPEXY (BREAST LIFT)
- BREAST REDUCTION (FEMALE)
- BREAST IMPLANT EXCHANGE/REMOVAL
- GYNECOMASTIA (MALE BREAST REDUCTION)
- POST-MASTECTOMY RECONSTRUCTION
- TREATMENT OF BREAST ASYMMETRY
- TREATMENT OF INVERTED NIPPLE

### FACIAL COSMETIC SURGERY

- FACE LIFT/CHEEK & NECK LIFT
- BROW LIFT
- UPPER EYELID BLEPHAROPLASTY
- LOWER EYELID BLEPHAROPLASTY
- CHIN ENHANCEMENT
- CHEEK ENHANCEMENT
- FAT INJECTIONS (FOR LACK OF FACIAL VOLUME)

### NASAL SURGERY

- RHINOPLASTY (COSMETIC NASAL SURGERY)
- SEPTOPLASTY (CORRECTION OF DEVIATED SEPTUM)
- NASAL TIP IMPROVEMENT

### COSMETIC EAR SURGERY

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

### SURGICAL BODY CONTOURING

- ABDOMINOPLASTY (TUMMY TUCK)
- THIGH LIFT
- MOMMY MAKEOVER
- SKIN REMOVAL AFTER MAJOR WEIGHT LOSS
- BRACHIOPLASTY (UPPER ARM LIFT)
- BUTTOCK LIFT
- SUCTION-ASSISTED LIPECTOMY (LIPOSUCTION):
  - ABDOMEN
  - THIGHS
  - NECK/CHIN
  - KNEES
  - ARMS
  - HIPS

### NON-SURGICAL BODY CONTOURING

#### VIORA REACTION

- CELLULITE REDUCTION
- SKIN TIGHTENING
- CIRCUMFERENTIAL REDUCTION (ARMS, THIGHS, TUMMY)
- NECK/JOWLS/CHIN TIGHTENING

#### PELLEVÉ WRINKLE REDUCTION SYSTEM

- FACIAL WRINKLE REDUCTION
- TREATMENT OF LINES AROUND MOUTH OR NASOLABIAL FOLDS
- TREATMENT OF EYE AREA

### FACIAL REJUVENATION

#### CLINICAL TREATMENTS

- LASER RESURFACING
- MICROLASER PEEL
- PROFRACTIONAL LASER TREATMENT
- BOTOX®/DYSPORT®
- DERMAL FILLERS

#### SPA TREATMENTS

- MICRODERMABRASION
- CHEMICAL PEELS
- CLINICAL FACIALS
- BROADBAND LIGHT (PHOTO FACIALS)
- HALO HYBRID FRACTIONAL LASER
- LASER HAIR REDUCTION
- HAIR REDUCTION (WAXING)
- ACNE TREATMENTS
- ROSACEA TREATMENTS
- LATISSE® (FOR THICKER, DARKER, LONGER LASHES)
- ENZA ESSENTIALS CUSTOMIZED SKIN CARE
- MAKE-UP CONSULTATION

#### OTHER

- VAGINAL REJUVENATION (DIVA LASER, LABIAPLASTY)
- SCAR IMPROVEMENT
- MOLE OR LESION REMOVAL
- TREATMENT FOR SKIN CANCER
- LASER NAIL FUNGUS TREATMENT
- HAND REJUVENATION OR CARPAL TUNNEL SYNDROME
- OTHER : \_\_\_\_\_

### CLINIC LOCATION:

- EAU CLAIRE  
3221 STEIN BLVD.
- RIVER FALLS  
1687 E DIVISION ST.
- DURAND  
1220 3<sup>RD</sup> AVE. W

### PLEASE TELL US HOW YOU FIRST HEARD ABOUT US

- FRIEND
- INTERNET
- TELEVISION
- DOCTOR REFERRAL
- OTHER: \_\_\_\_\_
- RADIO
- BILLBOARD
- PRINT AD
- SEMINAR

### WHAT PROMPTED YOU TO MAKE THIS APPOINTMENT?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_