Joseph H. Chang MD/ Modern Aesthetic Institute

Patient Information Form

Personal Information

Patient Name: _____

SS #: _____ DOB: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

Employer: _____ Occupation: _____

Address: _____

City: _____ State: _____ ZIP: _____

Emergency Contact Information

Name: _____ DOB: _____

Relationship to Patient: _____ Phone #: _____

Insurance Information

Primary Insurance: _____

Subscriber's Name: _____

Subscriber's SS#: _____ DOB: _____

ID#: _____ Group #: _____

Secondary Insurance: _____

Subscriber's Name: _____

Subscriber's SS#: _____ DOB: _____

ID#: _____ Group #: _____

I certify that the information on this form is correct to the best of my knowledge.

_____ _____

Patient Signature Date:

Joseph H. Chang MD/ Modern Aesthetic Institute

Medical History/ Review of Systems

Name:_____ Allergies to Meds:_____

Date of Birth:_____Sex: M/ F Height:_____Weight:_____

Primary MD:_____

DO YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING: (CIRCLE any that apply or none)

Cardiovascular: None/Heart Disease/High Blood Pressure/ Bleeding Disorder_____
Respiratory: None/ Asthma/ COPD
Gastrointestinal: None/ Hepatitis
Genitourinary: None
Skin/ Musculoskeletal: None/ Arthritis
Neurologic: None/ Previous Stroke

Endocrine: None/ Diabetes, Year Diagnosed:_____
Hematologic: None/ Easy Bleeding
Rheumatologic: None/ Lupus, RA, Fibromyalgia
Immunologic: None/ HIV-AIDS
Ear/ Nose/ Throat: None/ Allergies
General Health/Other:

FAMILY MEMBER WITH THE FOLLOWING:
DIABETES: Y/N RELATIONSHIP:_____

DO YOU DO THE FOLLOWING:
DRINK: Y/N How much:_____
SMOKE: Y/N How much:_____

MEDICATIONS (List All): ☐ None

_____
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NON-OCULAR SURGERIES: ☐ None

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FOR JHC MD/MAI USE ONLY

_____

OCULAR SURGERIES: ☐ None

Date: Procedure: Surgeon:

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OCULAR DIAGNOSES: ☐ None

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Initials/ Date

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HAVE YOU EVER HAD A PROBLEM WITH OUTPATIENT SURGERY OR ANESTHESIA? (Please explain)

☐ No/ ☐ Yes:_____