VININGS SURGERY CENTER

ROBERT A. COLGROVE, JR., M.D.

PATIENT INTAKE FORM

Dear Patient,

Thank you for contacting us regarding our services at Vinings Surgery Center and for scheduling an appointment with us. You can feel confident that our staff is committed to meeting your needs. Dr. Colgrove is looking forward to meeting you. Please be assured that Dr. Colgrove and his staff will work with you to prepare the best plan for you while taking the time to address all of your specific needs.

At Vinings Surgery Center, we strive to provide the most current, safe and effective procedures available today. By combining procedures that have stood the test of time with newly proven advances in technology, our office is on the cutting edge and able to provide you with the best options available.

In order to minimize your wait time, please complete these New Patient forms prior to your visit and bring them with you to your appointment. In the meantime, if you have any questions at all, please feel free to call our office. The entire office is dedicated to giving you the best experience possible.

If for any reason you are unable to keep your appointment, please contact us within 24 hours of your appointment to cancel or reschedule. We understand that some delays are unavoidable but please be aware that if you are 30 minutes late (or later), we will do our best to fit you in, but you may have to wait or reschedule.

Thank you for choosing Dr. Robert A. Colgrove, Jr., M.D. and Vinings Surgery Center!

Sincerely,

Robert A. Colgrove, Jr., M.D. and Staff

VININGS SURGERY CENTER
ROBERT A. COLGROVE, JR., M.D.

PATIENT INTAKE FORM

Date _____

Patient Name: _____
First Middle Last

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ (Required for surgery scheduling purposes)

Email Address: _____

Telephone: (Home) _____ (Cellular) _____ (Work) _____

Are there any restrictions for contacting you? ☐ Yes ☐ No

Age: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female ☐ TG

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnicity: _____

HOW DID YOU HEAR ABOUT US?

☐ Best Self Magazine
☐ The Barter Company
☐ BreastImplantsUSA.com
☐ ImplantForum.com
☐ ImplantInfo.com
☐ Ad in gym, club, restaurant
☐ JustBreastImplants.com
☐ Facebook/Instagram
☐ YouTube
☐ PlasticSurgery.com
☐ Radio Station _____
☐ RealSelf.com
☐ Internet Search
☐ Magazine
☐ Other _____

Referring Physician or Patient: _____

May we thank him/her? ☐ Yes ☐ No

Have you been to our website (www.Colgrove.com)? ☐ Yes ☐ No

If so, was our website helpful? ☐ Yes ☐ No

If NO, please list reason so we can improve this: _____

EMPLOYMENT INFORMATION

Occupation: _____

☐ Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Other

Employer/School: _____ Work Tel: _____

Is it ok to contact you at work? ☐ Yes ☐ No

SPOUSE CONTACT

(if applicable)

Name: _____ Spouse's Cell Tel: _____

Spouse's Employer: _____ Spouse's Work Tel: _____

EMERGENCY CONTACT

(Not in your Household)

Name: _____ Home Tel: _____

Relationship to Patient: _____ Work Tel: _____

Address: _____ Cellular: _____

City: _____ State: _____ Zip: _____

AREAS OF INTEREST

FACE	BREAST	BODY	AESTHETICS / SKIN
☐ Brow or Forehead Lift	☐ Breast Augmentation	☐ Arm Lift	☐ Botox and/or Facial Fillers
☐ Chin Augmentation	☐ Breast Asymmetry	☐ Buttock Augmentation	☐ Body Contouring/RF
☐ Ear Pinning (Otoplasty)	☐ Breast Implant Exchange	☐ Body Lift	☐ Chemical Peel
☐ Earlobe Repair	☐ Breast Lift (Mastopexy)	☐ Cellulite Reduction	☐ IPL/Fotofacial
☐ Eyelid Lift (Blepharoplasty)	☐ Breast Reconstruction	☐ Fat Transfer	☐ Laser Hair Reduction
☐ Facelift	☐ Breast Reduction	☐ Labia Reshaping	☐ Microdermabrasion
☐ Facial Liposuction	☐ Breast Revision/Repair	☐ Liposuction	☐ Skincare products for home
☐ Fat Injections	☐ Male Breast (Gynecomastia)	☐ Thigh Lift	☐ Skin Resurfacing
☐ Lip Enhancement	☐ Nipple Reduction/Inversion	☐ Tummy Tuck	☐ Skin Tightening/Firming
☐ Neck Lift	☐ Other:	☐ THERMItight/smooth/va	☐ Spider Veins
☐ Nose Reshaping (Rhinoplasty)		☐ Other:	☐ Wrinkle Reduction
☐ Other:			☐ Other:

If you have or have had any of the following conditions or illnesses, please let us know by checking the appropriate boxes.

CARDIOVASCULAR

Angina/Chest Pain	☐ Yes	☐ No
Blood Pressure Abnormalities	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Heart Bypass Surgery	☐ Yes	☐ No
Heart Failure	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No

RESPIRATORY

Abnormal Chest X-ray	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Cough with Mucus or Blood	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Major Allergies	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Recent Chest Infection	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Shortness of Breath at night	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Use a C-PAP Machine	☐ Yes	☐ No

GASTROINTESTINAL

Bloody Bowel Movements	☐ Yes	☐ No
Colitis	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Gallstones	☐ Yes	☐ No
Gastritis	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Hemorrhoids	☐ Yes	☐ No
Hiatal Hernia	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Liver Disease (Cirrhosis)	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No

ENDOCRINE

Diabetes	☐ Yes	☐ No
Hyperthyroidism	☐ Yes	☐ No
Hypothyroidism	☐ Yes	☐ No
Hypoglycemia	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No

PSYCHIATRIC

Alcoholism or Drug Dependency	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Obsessive Compulsive Disorder	☐ Yes	☐ No
Psychiatric Hospitalization/Care	☐ Yes	☐ No

NEUROLOGICAL

Arthritis	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Herniated Disc	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No
Palsy or Paralysis	☐ Yes	☐ No
Rheumatoid	☐ Yes	☐ No
Sciatica	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Stroke	☐ Yes	☐ No

HEMATOLOGIC/ONOCOLOGIC

Anemia	☐ Yes	☐ No
Bleeding Tendency or Disorder	☐ Yes	☐ No
Blood Clots in Legs	☐ Yes	☐ No
Blood Clots in Lungs	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No
Positive blood test for HIV/AIDS	☐ Yes	☐ No
Radiation Therapy	☐ Yes	☐ No
Sickle Cell Disease	☐ Yes	☐ No

SKIN

Atypical Skin Lesions	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Piercing other than Ears	☐ Yes	☐ No
Radiation	☐ Yes	☐ No
Accutane within 6 months	☐ Yes	☐ No
Herpes Simplex Virus 1 or HSV2	☐ Yes	☐ No

OTHER

Airway Obstruction (Nasal)	☐ Yes	☐ No
Kidney or Renal Disease	☐ Yes	☐ No
Missed or Irregular Period	☐ Yes	☐ No
Breast Cysts or Tumors	☐ Yes	☐ No
Fractured bones/breaks	☐ Yes	☐ No
Nipple Discharge (not from normal lactation)	☐ Yes	☐ No

EYES/MOUTH

Cataracts	☐ Yes	☐ No
Dry Eyes	☐ Yes	☐ No
Glaucoma or Eye Problems	☐ Yes	☐ No
Visual Disturbances	☐ Yes	☐ No
Error in Refraction	☐ Yes	☐ No
Do you wear Contact Lenses	☐ Yes	☐ No
Cosmetic bonding to teeth	☐ Yes	☐ No
Dentures, bridges, caps or crowns	☐ Yes	☐ No
Loose teeth	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No

Have any of your family members unexpectedly died following anesthesia or exercise? ☐ Yes ☐ No
If yes, please explain _____

Do you have a family or personal history of malignant hyperthermia? ☐ Yes ☐ No

Do you have a family or personal history of a muscle or neuromuscular disorder? ☐ Yes ☐ No

Do you have a family or personal history of high temperature following exercise? ☐ Yes ☐ No

Do you have a personal history of muscles spasm? ☐ Yes ☐ No

Do you have a personal history of dark or chocolate-colored urine? ☐ Yes ☐ No

Do you have a personal history of unanticipated fever immediately following anesthesia or serious exercise? ☐ Yes ☐ No

HOSPITALIZATIONS & SURGERIES

Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons

Where	When	Why

1. Do you have an allergic reaction to any medication? ☐ Yes ☐ No Which? _____

2. Do you react abnormally to any medication? ☐ Yes ☐ No Which? _____

3. Are you allergic to Latex? ☐ Yes ☐ No

4. Are you allergic to Iodine? ☐ Yes ☐ No

5. Have you or any member of your family ever had any difficulties with any medications, drugs, or gases used for anesthesia? ☐ Yes ☐ No

6. Have you ever been on cortisone or steroid treatment? ☐ Yes ☐ No When? _____

7. Do you drink alcoholic beverages including beer, wine or other alcohol regularly? ☐ Yes ☐ No
If so, how much? _____

8. Do you smoke or use tobacco products? ☐ Yes ☐ No
If so, how much? _____ For how long? _____

9. Are you pregnant? ☐ Yes ☐ No When was your last menstrual period? _____
(You cannot have surgery if you are pregnant)

10. How many pregnancies? _____ Births? _____ Breast Fed? ☐ Yes ☐ No How long? _____

11. What form of birth control do you use? _____

12. When was your last physical exam? _____

13. How would you describe your health? ☐ Good ☐ Fair ☐ Poor

14. When was your last eye exam? _____ By whom? _____
When and where was your last CHEST X-RAY ? _____
MAMMOGRAM?_____ EKG? _____

15. Who is your personal physician, if any? _____ Please list all doctors caring for you with phone number: _____

16. Have you ever been under psychiatric care? ☐ Yes ☐ No
When? _____ Why? _____

17. Have you ever been diagnosed with anorexia, bulimia or any eating disorder? ☐ Yes ☐ No

18. Have you had any recent blood work done? ☐ Yes ☐ No If so, where? _____

19. Do you have sleep apnea? ☐ Yes ☐ No Do you use a C-PAP machine? ☐ Yes ☐ No

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Initial Consult Worksheet

Patient Name: _____

Yes No Are you currently taking aspirin or Advil?

Yes No Are you on Coumadin or other blood thinners?
If yes, list: _____

Yes No Are you taking diet pills, herbal supplements or energy drinks?
If yes, list: _____

Yes No Are you on hormone replacement therapy or birth control pills?

Yes No Is there anything else you think the doctor should know or are there ANY other major health concerns? If yes, list_____

Please list all present medications, including birth control pills, hormones, vitamins, herbal medications, diuretics and weight loss drugs. **Include over-the-counter medications.**

Name	Dosage	How Often Taken

FOR OFFICE USE ONLY

Height: _____ **Blood Pressure:** _____

Weight: _____ **Rate:** _____

BMI: _____ **Initial:** _____

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I agree to stop smoking 2 weeks before and 2 weeks after surgery ☐ Yes ☐ No

By signing below, I agree that the information is complete and accurate to the best of my knowledge.

Signature _____ Date _____

I hereby acknowledge that a copy of Vinings Surgery Center's Notice of Privacy Practices regarding the use and disclosure of my personal health information was made available for me to review.

Patient/Responsible Party Signature _____ Date _____

I hereby authorize Dr. Robert A. Colgrove, Jr. to release to my insurance company or to any health care financing organization any information concerning my illness or treatment. I hereby assign to the physician all payments for medical services rendered to myself or my dependent. I permit a copy of this authorization to be used in place of the original. I have read the attached Office Policy and I understand and agree to its terms. I hereby give consent to Dr. Colgrove to take photographs of my injury or requested areas of discussion. Such pictures are to be used for scientific or educational purposes.

Patient/Responsible Party Signature _____ Date _____

AUTHORIZATION FOR DISCLOSURE OF INFORMATION:

I authorize Dr. Robert Colgrove to disclose complete information concerning his medical findings and treatment of the undersigned, from the initial office visit until the date of the conclusion of such treatment, to those individuals who, in Dr. Robert A. Colgrove's sole determination, are required to receive such information *for the purpose of medical treatment, medical quality assurance and peer review.*

Patient's Signature_____ Date _____

- ☐ After your consultation, we may mail you a survey, follow-up letter, and additional information to the postal address that you supplied. If you would prefer that we do not contact you in this way, please check this box.

May we contact you through email? If yes, please provide your email address:

_____

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In the medical community, we must abide by a very strict set of laws that are in place to protect you and your privacy (HIPPA). These guidelines maintain your privacy and confidentiality as well as other patients' privacy and confidentiality that may be in the office when you are present. If you make an audio or video recording in a medical office, you could potentially be violating the law, and that has very serious ramifications. We kindly ask that you refrain from doing this.

Thank you for understanding, and we look forward to maintaining your trust and confidence in us as we help you achieve your personal best!

I have received Vinings Surgery Center' s policy on patient audio/video recordings, and I agree to abide by the express request to refrain from any and all recordings while in the facility, including areas that are public and/or private.

Signature_____ Date_____