



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?

- | | | |
|--|--|--|
| <input type="checkbox"/> Best Self Magazine | <input type="checkbox"/> Ad in gym, club, restaurant | <input type="checkbox"/> Radio Station _____ |
| <input type="checkbox"/> The Barter Company | <input type="checkbox"/> JustBreastImplants.com | <input type="checkbox"/> RealSelf.com |
| <input type="checkbox"/> BreastImplantsUSA.com | <input type="checkbox"/> Facebook/Instagram | <input type="checkbox"/> Internet Search |
| <input type="checkbox"/> ImplantForum.com | <input type="checkbox"/> YouTube | <input type="checkbox"/> Magazine |
| <input type="checkbox"/> ImplantInfo.com | <input type="checkbox"/> PlasticSurgery.com | <input type="checkbox"/> 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
<input type="checkbox"/> Brow or Forehead Lift	<input type="checkbox"/> Breast Augmentation	<input type="checkbox"/> Arm Lift	<input type="checkbox"/> Botox and/or Facial Fillers
<input type="checkbox"/> Chin Augmentation	<input type="checkbox"/> Breast Asymmetry	<input type="checkbox"/> Buttock Augmentation	<input type="checkbox"/> Body Contouring/RF
<input type="checkbox"/> Ear Pinning (Otoplasty)	<input type="checkbox"/> Breast Implant Exchange	<input type="checkbox"/> Body Lift	<input type="checkbox"/> Chemical Peel
<input type="checkbox"/> Earlobe Repair	<input type="checkbox"/> Breast Lift (Mastopexy)	<input type="checkbox"/> Cellulite Reduction	<input type="checkbox"/> IPL/Fotofacial
<input type="checkbox"/> Eyelid Lift (Blepharoplasty)	<input type="checkbox"/> Breast Reconstruction	<input type="checkbox"/> Fat Transfer	<input type="checkbox"/> Laser Hair Reduction
<input type="checkbox"/> Facelift	<input type="checkbox"/> Breast Reduction	<input type="checkbox"/> Labia Reshaping	<input type="checkbox"/> Microdermabrasion
<input type="checkbox"/> Facial Liposuction	<input type="checkbox"/> Breast Revision/Repair	<input type="checkbox"/> Liposuction	<input type="checkbox"/> Skincare products for home
<input type="checkbox"/> Fat Injections	<input type="checkbox"/> Male Breast (Gynecomastia)	<input type="checkbox"/> Thigh Lift	<input type="checkbox"/> Skin Resurfacing
<input type="checkbox"/> Lip Enhancement	<input type="checkbox"/> Nipple Reduction/Inversion	<input type="checkbox"/> Tummy Tuck	<input type="checkbox"/> Skin Tightening/Firming
<input type="checkbox"/> Neck Lift	<input type="checkbox"/> Other:	<input type="checkbox"/> THERMItight/smooth/va	<input type="checkbox"/> Spider Veins
<input type="checkbox"/> Nose Reshaping (Rhinoplasty)		<input type="checkbox"/> Other:	<input type="checkbox"/> Wrinkle Reduction
<input type="checkbox"/> Other:			<input type="checkbox"/> 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/ONCOLOGIC

- 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



VININGS SURGERY CENTER
 — ROBERT A. COLGROVE, JR., M.D. —
 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: _____



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

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 _____



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

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 _____