

AUTHORIZATION FOR EXAMINATION

Name: _____ Birthdate: _____
Address: _____ Soc. Sec Number: _____
Home Phone: _____
City: _____ State: _____ Zip: _____ Work Phone: _____

Insurance: Yes () No ()

I, _____, represent to the physicians and staff that I am at least 18 (eighteen) years of age, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and he may assign such assistant or staff as may be assigned by him/her.

I authorize the release of any medical information for the purpose of processing insurance

Signature: _____

Date: _____

Relationship: (circle)

Parent

Spouse

Guardian

Other

Michael Olding, M.D.
Plastic and Reconstructive Surgery

Patient Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____ Occupation: _____

Reason for visit: _____ Cell# _____ Home# _____

Who referred you to this office: _____

Who is your regular Medical Doctor: _____

Are you allergic, or have you reacted badly to:

- | | | |
|--|-----|----|
| 1. Local Anesthetic | yes | no |
| 2. Penicillin | yes | no |
| 3. Codeine or other pain killers | yes | no |
| 4. Aspirin | yes | no |
| 5. Others (please list) | yes | no |

Please list all medication which you are currently taking or have used in the past 6 months (be sure to include any of the following: birth control pills, aspirin, or ibuprofen containing drugs, diet pills, diabetic medications, steroids, glaucoma drops, asthma medications, Digoxin, Lanoxin, nitroglycerin, Isordil, Inderal, other heart medications, Lasix, other diuretics, high blood pressure medications, Coumadin, Persantine, tranquilizers, sleeping pills, anti-depressants, pain pills or shots, epilepsy medications).

Medication(s)	Amount	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you Bleed or Bruise easily? yes no

Are you a Smoker? yes no Ex-Smoker? yes no Non-Smoker? yes no
 How much are (were) you smoking? _____ For how long? _____ Quit how long ago? _____

Please circle all of the following medical conditions you now have or have had in the past:

- | | | | | | |
|-------------------------------|---------------------------|---|----------------------|------------|------------|
| Bleeding Tendency | Hepatitis | Diabetes | Blood Transfusions | Glaucoma | Dry Eyes |
| Lung Disease | TB | Emphysema | Asthma or Wheezing | Bronchitis | Chest Pain |
| Heart Disease | Heart Attack | Stroke | Irregular Heart Beat | Epilepsy | Heart Burn |
| Intestinal Ulcers or Bleeding | | High Blood Pressure | | Depression | |
| Mental Illness | Drug or Alcohol Addiction | Any Other Serious Illness or Injury _____ | | | |

Is there any possibility that you may be pregnant at this time? yes no

List any surgeries that you have had (include plastic surgery): _____ Date: _____

Have you or anyone in your family ever had unusual reactions to anesthesia (muscle weakness, jaundice, breathing problems, or unexpected fevers)? yes no

Do you have (please circle all that apply): loose or chipped teeth / caps / dentures / contact lenses

Have you ever seen a cardiologist? yes no Physician Name: _____
 Date of last EKG: _____

Patient Signature: _____ Date: _____