Cosmetic Surgeons of Naples
Nalin Master MD and Rebecca Crane MD
671 Goodlette Road North, Suite 110, Naples, FL 34102
(239) 263-6766

PLEASE PRINT OR WRITE LEGIBLY

Reason For Visit: ____

Referred by: ____

Patient Information:

Name: ____ Male / Female
First M.I. Last Please Circle One

Address: ____
Street Address Apt. # City State Zip

Phone: Home ( ) ______________ Work ( ) ________________ Cell ( )______________

Birthdate: ________________ Age: ______ SS # ______-______-________ Marital Status: ______________

Preferred Language________________

Ethnicity – Not Hispanic or Latin ___ Hispanic or Latin __

Patient Race ____________________________

Employer: ____ Occupation: ____________________

Employer Address: ____

Spouse/Parent's Name: ___________________________ D.O.B______________ SS#_________________

In Case of Emergency, Contact:

Name: ____ Relationship: ___________________

Phone: Home ( ) ________________ Work ( ) _________________ Cell ( )________________

Permission To Leave Message:

Telephone: ______Yes ______No
E Mail: _______Yes ______No
Text: _______Yes ______No
Name: __________________________________

E Mail Address: ______________________________________

Primary Care Physician or Medical Doctor:

Name: ____ Phone # ( ) __________________

When was your last visit with your PCP/MD? Month ________________________ Year __________________

I authorize **Cosmetic Surgeons of Naples, Nalin Master MD and Rebecca Crane MD** to render treatment as deemed necessary by the physicians of the Group. I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such care, to third party payors and/or other health practitioners. I authorize payment for services rendered to be paid directly to **Cosmetic Surgeons of Naples, Nalin Master MD and/or Rebecca Crane MD**. I agree to be responsible for payment of all services rendered to my dependents or myself. If an account is referred to an outside agency for collection, patients shall be liable for all costs of collection, and any attorney fees and court costs incurred by this office, including interest at the rate of 18 percent per annum (1.5 percent per month).

Patient/Guardian Signature: ____ Date: __________________

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Insurance Statement

Does your insurance company require a referral from your primary care physician? Have you obtained that referral? Because most managed care plans do not issue referral numbers after the date of service, the referral must be received by the time of your visit or you will be required to pay for the services.

Are you restricted to seeing only certain doctors?

Look at your insurance card. A toll free number is usually listed on the back of the card. Someone with your insurance company will be able to answer your questions.

I hereby understand that I am responsible for giving "Cosmetic Surgeons of Naples, Nalin Master MD and Rebecca Crane MD" the correct insurance information. Cosmetic Surgeons of Naples, Nalin Master MD and Rebecca Crane MD will bill primary and secondary carriers. However, all information must be provided at the initial time of service.

I also understand that I am responsible for obtaining the proper referral and agree to pay for services for which I failed to obtain a proper referral.

I agree to pay for non-covered services under my insurance plan (services for which I have a policy exclusion).

I understand that Cosmetic Surgeons of Naples, Nalin Master MD and Rebecca Crane MD is not responsible for knowing if the group/physician is a participating provider with my insurance carrier.

I understand that I am responsible for all balances not paid by my insurance, including out-of-network penalties, deductibles, and co-insurances.

I authorize and request my insurance company to make payments directly to Cosmetic Surgeons of Naples, Nalin Master MD and/or Rebecca Crane MD for services rendered.

I understand that my insurance carrier may pay none or less than the actual bill for services.

Patient/Guardian Signature: ____ Date: ___________________

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Insurance Cards

Primary Insurance Information:

Insurance Name: ____

Address: ____

Phone # (   ) ____

Employer: ______________________________ Employer Phone # ____________________

Insured's Name: ______________________________ Social Security # ______-_______-_________

Insured's Birthdate: ______________________________ Relationship to Patient: ________________

Insured's Identification # ______________________________ Group # ____________________

Secondary Insurance Information:

Insurance Name: ____

Address: ____

Phone # (   ) ____

Employer: ______________________________ Employer Phone # ____________________

Insured's Name: ______________________________ Social Security # ______-_______-_________

Insured's Birthdate: ______________________________ Relationship to Patient: ________________

Insured's Identification # ______________________________ Group # ____________________

Patient/Guardian Signature: ____ Date: ________________

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Medical History

Name: ____ Date: ________________
Birthdate: ______________ Age: _________ Sex: ________ Height: _________ Weight: __________

Please circle "Y"es or "N"o to indicate if you have or have had any of the following:

Condition				Condition			
AIDS/HIV	Y	N	________	Hemophilia	Y	N	________
Anemia/"Low Blood"	Y	N	________	Hepatitis	Y	N	________
Arthritis	Y	N	________	High Blood Pressure	Y	N	________
Artificial Heart Valves	Y	N	________	Low Blood Pressure	Y	N	________
Artificial Joints	Y	N	________	Mitral Valve Prolapse	Y	N	________
Back Problems	Y	N	________	Nervous Problems	Y	N	________
Bleeding Disorders	Y	N	________	Phlebitis	Y	N	________
Blood Clots	Y	N	________	Psychiatric Care	Y	N	________
Cancer	Y	N	________	Radiation Treatment	Y	N	________
Cardiac Arythmia	Y	N	________	Respiratory	Y	N	________
Chemical Dependency	Y	N	________	Rheumatic Fever	Y	N	________
Chronic Cough	Y	N	________	Stomach Ulcers/Reflux	Y	N	________
Coronary Artery Disease	Y	N	________	Stroke	Y	N	________
Congestive Heart Failure	Y	N	________	Thyroid Disease	Y	N	________
Diabetes	Y	N	________	Tuberculosis	Y	N	________
Depression	Y	N	________	Ulcers	Y	N	________
Eye Problems	Y	N	________				
Epilepsy/Seizure Disorder	Y	N	________	Other – Specify ________			
Gout	Y	N	________	________			
Headaches	Y	N	________	________			
Heart Problems	Y	N	________				

For Women:			
	Are you pregnant?	Y	N
	Are you presently nursing?	Y	N
	Date of Last Menstrual Period: ________________		
	Do you take hormone supplements?	Y	N
	Have you ever been diagnosed with osteoporosis?	Y	N

MEDICATIONS: Include prescription, over the counter, and vitamins- include strength & frequency:

____
____
____
____

ALLERGIES: Please indicate if you have an allergy to the following.

Adhesive Tape	Y	N	Intravenous Dyes	Y	N	Seafood/Shellfish	Y	N
Aspirin	Y	N	Latex Rubber	Y	N	Soy/Egg Products	Y	N
Codeine	Y	N	Local Anesthetics	Y	N	Sulfa Drugs	Y	N
Demerol	Y	N	Novocaine	Y	N	Other: ________________		
Iodine	Y	N	Penicillin	Y	N	________________		

Pharmacy Name: ____________________________________ Address______________________________
Pharmacy Phone: (   ) ________________________________

Patient/Guardian Signature: ____ Date: _________________

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Surgical History

Please circle "Y"es or "N"o if you have ever had any of the following:

Appendectomy	Y	N
Colonoscopy:		
Screening	Y	N
With Polypectomy	Y	N
Colon Resection:		
Large Intestines	Y	N
Colostomy	Y	N
Small Intestines	Y	N
Cataracts/Eye Surgery	Y	N
Gall Bladder		
Laparoscopic	Y	N
Open	Y	N
Heart Bypass	Y	N
Heart Valve Replacement	Y	N
Hernia		
Open Inguinal Left	Y	N
Open Inguinal Right	Y	N
Laparoscopic Inguinal Left	Y	N
Laparoscopic Inguinal Right	Y	N
Ventral Hernia Open	Y	N
Ventral Hernia Laparoscopic	Y	N
Umbilical Hernia Open	Y	N
Umbilical Hernia Laparoscopic	Y	N
Hysterectomy	Y	N
Hip Replacement	Y	N
Knee Replacement	Y	N
Lumpectomy		
Right Breast	Y	N
Left Breast	Y	N
Mastectomy		
Right Breast	Y	N
Left Breast	Y	N
Surgical Repair of Broken Bones	Y	N
Reconstructive/Plastic Surgery	Y	N
Surgery for Ulcers	Y	N
Surgery on Lungs	Y	N
Transplant (organ)	Y	N
Tubal Ligation	Y	N

Other: ____

Have you ever healed with thick, disfigured, or keloid scars?	Y	N
Have you ever had any problems with slow healing of surgical incisions?	Y	N
Have you ever had a blood transfusion?	Y	N
Have you ever had any problems with anesthesia in the past?	Y	N
Is there a history in your family of malignant hyperthermia with anesthesia?	Y	N
Do you routinely take aspirin, over-the-counter anti-inflammatories, or anticoagulants?	Y	N

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Family History

Please circle "Y"es or "N"o if anyone in your family has (or has had) and your relationship (i.e., mom, dad, aunt, brother, etc):

Arthritis	Y	N	_______________	High Blood Pressure	Y	N	______________
Bleeding Disorders	Y	N	_______________	Nerve Disease	Y	N	______________
Cancer	Y	N	_______________	Stroke	Y	N	______________
Diabetes	Y	N	_______________	Ulcers	Y	N	______________
Heart Disease	Y	N	_______________	Other: ____			

Mother living Y Age ____ Medical Problems____

N Age ____ Cause of Death ____

Father living Y Age ____ Medical Problems____

N Age ____ Cause of Death ____

Personal History

Do you use tobacco products? Y N

Packs/Day ______________ Years Smoked ________

Cigars/Day ______________ Pipe ________________

Chewing Tobacco? Y N

Do you use alcohol products? Y N

How much do you drink? ________________________

How often do you drink? ________________________

If you quit, how long has it been since your last smoke? ____

Do you currently use, or have used in the past, any substance or any prescription narcotic in excess that may injure or may have contributed to any health problems? Y N

Occupation: ____

Activities:

Do you actively participate in a workout regimen? Y N

How frequently do you workout? ________________________

Do you walk, run or jog? (Please circle) How often and for how long? (time, distance): ______________________________

What sports do you participate in? ____

Patient/Guardian Signature: ____ Date: ______________________

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Review of Systems

Constitutional Symptoms

Good general health lately Y N
Recent weight change Y N
Fever Y N
Fatigue Y N

Integumentary (skin, hair,nails)

Skin: Rash or itching Y N
Skin: Change in color Y N
Skin: Eruptions Y N
Skin: Scaling Y N
Skin: Bruising Y N
Skin: Sores or Ulcers Y N
Skin: Unhealed Sores or Ulcers Y N
Skin: Bleeding Y N
Hair: Change in color Y N
Hair: Change in texture Y N
Hair: Abnormal loss Y N
Hair: Abnormal growth Y N
Nails: Change in color Y N
Nails: Brittleness Y N
Nails: Ridging Y N
Nails: Pitting Y N
Nails: Curvature Y N

Head

Headaches Y N
Migraines Y N
Trauma Y N
Vertigo Y N
Convulsive seizures Y N

Eyes

Eye disease or injury Y N
Wear glasses or contact lenses Y N
Blurred or double vision Y N
Color Blindness Y N
Diplopia Y N
Trauma Y N
Inflammation Y N
Loss of vision left Y N
Loss of vision right Y N
Acute changes in vision Y N

Ears/Nose/Mouth Throat/Neck

Ears: Hearing loss or ringing left Y N
Ears: Hearing loss or ringing right Y N
Ears: Hearing aid left Y N
Ears: Hearing aid right Y N
Ears: Pain left Y N
Ears: Pain right Y N
Ears: Discharge from ears Y N
Nose: Rhinitis Y N
Nose: Sinusitis Y N
Nose: Discharge Y N
Nose: Obstruction Y N
Mouth: Soreness of mouth or tongue Y N
Mouth: Slurred Speech Y N
Mouth: Bleeding Sore Y N
Mouth: Gum disease Y N
Throat: Hoarseness Y N
Throat: Sore throat Y N
Throat: Tonsillitis Y N
Throat: Voice changes Y N
Neck: Swelling Y N
Neck: Suppurative lesions Y N
Neck: Enlarged lymph nodes Y N
Neck: Goiter Y N
Neck: Stiffness Y N
Neck: Limit of motion Y N

Cardiovascular

Chest pain or angina pectoris Y N
Palpitations Y N
Shortness of breath with Walking or lying flat Y N
Swelling of feet, ankles, or hands Y N
Nocturnal dyspnea Y N
Cold extremities Y N

Respiratory

Chronic or frequent coughs Y N
Productive cough Y N
Spitting up blood Y N
Shortness of breath Y N
Wheezing Y N
Night sweats Y N

Gastrointestinal

Loss of appetite Y N
Change in bowel Movements Y N
Nausea or vomiting Y N
Frequent diarrhea Y N
Painful bowel movements or constipation Y N
Rectal bleeding or blood in stool Y N
Abdominal pain Y N

Genitourinary

Frequent urination Y N
Burning or painful urination Y N
Blood in urine Y N
Change in force of stream when urinating Y N
Incontinence or dribbling Y N
Kidney Stones Y N
Sexual difficulty Y N
Male-testicle pain Y N
Female-pain with periods Y N
Female-irregular periods Y N
Female-vaginal discharge Y N
Female-# of pregnancies______
Female-# of miscarriages______
Female-Date of last pap smear _______

Musculoskeletal

Joint pain Y N
Joint stiffness or swelling Y N
Weakness of muscles or joints Y N
Muscle pain or cramps Y N

Neurological

Frequent or recurring	
Headaches	Y N
Light headed or dizziness	Y N
Convulsions or seizures	Y N
Numbness or tingling	Y N
Tremors	Y N
Paralysis	Y N

Hematologic/Lymphatic

Slow to heal after cuts	Y N
Bleeding or	
bruising tendency	Y N
Anemia	Y N
Phlebitis	Y N
Past transfusion	Y N
Enlarged glands	Y N

Psychiatric

Memory loss or	
Confusion	Y N
Nervousness	Y N
Depression	Y N
Insomnia	Y N

Endocrine

Glandular or	
hormone problem	Y N
Excessive thirst	
or urination	Y N
Heat or cold intolerance	Y N
Skin becoming dryer	Y N
Change in hat	
or glove size	Y N

Hepatic System

Cirrhosis	Y N
Hepatitis	Y N
Abnormal liver enzymes	Y N

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services that I may need.

Patient/Guardian Signature: ____

Date: ___________________

Doctor's Review:

Doctor Signature: ____

Date: ___________________