

PLASTIC SURGERY CENTER, INC.  
BRUCE E. BURNHAM, M.D.  
PATIENT INFORMATION

SOCIAL SECURITY #: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ AGE: \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: HOME: \_\_\_\_\_ CELL: \_\_\_\_\_ WORK: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

MARITAL STATUS: M D W S SPOUSE SS # \_\_\_\_\_

SPOUSE/PARTNER: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ PHONE # \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE# \_\_\_\_\_

**REASON FOR CONSULTATION:** \_\_\_\_\_

CIRCLE ALL THAT APPLY

AREA(S) OF CONCERN: FULL FACE FOREHEAD BROWS CROWSFEET UPPERLIDS LOWER LIDS NOSE

LIPS NECK EARS BREAST ABDOMEN BACK WAIST HIPS INNER & OUTER THIGHS BUTTOCKS KNEES

**PRIOR SURGERIES:** BREAST ENLARGEMENT \_\_\_\_\_ BREAST REDUCTION \_\_\_\_\_ LIPOSUCTION \_\_\_\_\_

FACELIFT \_\_\_\_\_ UPPER EYELIDS \_\_\_\_\_ LOWER EYELIDS \_\_\_\_\_ NASAL SURGERY \_\_\_\_\_

BOTOX \_\_\_\_\_ COLLAGEN \_\_\_\_\_ LASER SURGERY \_\_\_\_\_ LASER HAIR REMOVAL \_\_\_\_\_

**Have you consulted with another Plastic Surgeon? Name:** \_\_\_\_\_

MEDICATIONS YOU CURRENTLY TAKE: \_\_\_\_\_

ANY ALLERGIES TO MEDICATIONS? YES NO IF YES, WHICH ONES \_\_\_\_\_

HAVE YOU EVER HAD A REACTION TO PENICILLIN? \_\_\_\_\_

NAME OF PHARMACY: \_\_\_\_\_ PHONE #: \_\_\_\_\_

WERE YOU REFERRED BY A FRIEND OR PREVIOUS PATIENT? \_\_\_\_\_  
NAME

**I agree to allow Dr. Burnham or a person of his staff to take a face photo of me at my consultation for identification purposes.** Y N

**I agree to allow Dr. Burnham to take photographs of the areas I am consulting for.** Y N

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service or two weeks prior to surgery unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. A returned check fee of \$20.00 will be added to all returned checks, regardless of cause.

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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**INSURANCE INFORMATION:** IF YOU ARE BEING SEEN FOR A **COVERED** PROCEDURE, PLEASE FILL OUT THE FOLLOWING SECTION.

I THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH

\_\_\_\_\_ AND I ASSIGN DIRECTLY TO DR. BURNHAM ALL INSURANCE BENEFITS  
(NAME OF INSURANCE COMPANY)

OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.** I HEREBY AUTHORIZE THE DOCTOR TO RELEAASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

X \_\_\_\_\_  
SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP DATE

We would like a copy of your insurance card, if we are submitting to your insurance company.