Stephen M. Miller, M.D., P.C., F.A.C.S.
Certified by The American Board of Plastic Surgery

Date: _____

Name: _____

Date of Birth:_____/_____/_____ Age:_____ Sex:_____ Marital Status:_____

Address:_____

City: _____State:_____ Zip:_____

Home Phone: _____Cell Phone: _____

E-mail: _____
_____ Please initial your approval to send or e-mail information.

What is the best way to reach you? _____

Employer:_____ Occupation: _____

Work Phone: _____

Spouse Name: _____ DOB: _____/_____/_____
_____ Please initial if we have permission to discuss your medical history with spouse.

Employer:_____ Phone:_____

Emergency Contact: _____

Relationship: _____ Phone: _____

Who referred you to this office? _____

Reason for Consultation: _____

Other health issues and procedures or products of interest to you (please check all that apply):

___ Cosmetic Surgery_____
___ BOTOX Cosmetic™ (Botulinum Toxin Type A)
___ Juvederm Injectable Filler
___ Latisse Eyelash Growth Product
___ Meet with Aesthetician
___ Facial Treatments (Hydrafacial, Peels, IPL, Microneedling, Thermage)
___ Skin Care Products
___ Other, please specify _____

Signature of responsible party:_____

Eastern Professional Plaza • 8435 S. Eastern • Las Vegas, Nevada 89123
Phone (702) 369-1001 • Fax (702) 369-3030

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Patient Name_____ **Date** _____

Past Medical History

1. List any past surgeries and/or past serious illnesses. List the dates they occurred.

_____

_____

_____

2. Do you have any allergies to medications? (If so, please list.)

_____

3. List any medications, supplements, vitamins or herbal medications you are taking.

_____

_____

Personal Medical History – Patient to fill out

	YES	NO		YES	NO		YES	NO
High Blood Pressure	___	___	Stroke	___	___	Hernias	___	___
Thyroid trouble	___	___	Heart Failure	___	___	Arthritis	___	___
Epilepsy	___	___	Chest Pain	___	___	Back Injuries	___	___
Severe Headaches	___	___	Palpitations	___	___	Mental Disorder	___	___
Rheumatic Fever	___	___	Bleeding Disorder	___	___	Depression	___	___
Hearing problems	___	___	Kidney Disease	___	___	Diabetes	___	___
Shortness of breath	___	___	HIV	___	___	Hepatitis	___	___
Asthma	___	___	Liver Problems	___	___	Cancer	___	___
Emphysema	___	___	Bladder Problems	___	___	Blood Transfusion	___	___
Heart problems	___	___	Weight Gain/Loss	___	___	Bruise easily	___	___

Please list any other serious illneses_____

	YES	NO	
Are you Pregnant?	___	___	
Do you smoke?	___	___	How much/long?_____/_____
Do you drink alcoholic beverages?	___	___	How much/long?_____/_____
Do you take street or addicting drugs?	___	___	How much/long?_____/_____
Do you take aspirin or Ibuprofen?	___	___	How much/long?_____/_____

Have you or a family member had an unusual reaction to anesthesia? YES___ NO ___

Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Signed_____ Date:_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Stephen M. Miller, M.D., P.C. to release information requested by my insurance company or workmen's compensation carrier. I also authorize Stephen M. Miller, M.D., P.C. to release information to any hospitals, Surgery Centers or Physicians I may be referred to by this office.

Signature: _____ Date: ____/____/_____
Relationship to Patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(To be filed in patient's medical record)

I have been presented with a copy of Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Patient signature: _____ Date: ____/____/_____
Relationship (if not signed by patient): _____

Internal Use Only:
If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date and time): ____/____/_____ _____ am/pm
By (name and title): _____

WE REQUEST PAYMENT OF FEES FOR THE OFFICE SERVICES AND VISITS AT THE TIME SERVICES ARE RENDERED.

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