Bellefonte Cosmetic
AND RECONSTRUCTIVE SURGERY

1000 Ashland Dr., Suite 303
Ashland, KY 41101
(606) 325-0753
www.bellefontecrs.com

Phillip Lackey, M.D.

PATIENT INFORMATION

Date: _____ Primary Care Physician: _____

Referred By: _____ Preferred Pharmacy: _____

Patient Name: _____ DOB: _____ Age: _____

Social Security No.: _____

Marital Status: S M W D Sep. Sex: M F

Address: _____ City/State/Zip Code: _____

Home Telephone: _____ Cell: _____ Work: _____

Email Address: _____

Patient's Employer: _____ Occupation: _____

Employer's Address: _____ City: _____

State: _____ Zip Code: _____

SPOUSE/PARENT INFORMATION

Spouse/Parent Name: _____ DOB: _____

Home Telephone: _____ Cell: _____ Work: _____

Employer: _____ Occupation: _____

Employer's Address: _____ City: _____

State: _____ Zip Code: _____

RESPONSIBLE PARTY INFORMATION

Name of Responsible Party: _____ DOB: _____

Social Security No.: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Home Telephone: _____ Cell: _____ Work: _____

Employer: _____

Occupation: _____

Employer Address: _____ City: _____

State: _____ Zip Code: _____

IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Home Telephone: _____ Work: _____ Cell: _____

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I authorize Dr. Lackey 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. Lackey's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

Patient Signature: _____ Date: _____

Witness: _____

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RELEASE AND/OR DISCUSSION OF MEDICAL INFORMATION

Patient Name: _____

Date: _____

Patient Birthday: _____

I, _____ DO HEARBY AUTHORIZE BELLEFONTE COSMETIC AND RECONSTRUCTIVE SURGERYAND/OR THEIR STAFF TO RELEASE MY MEDICAL INFORMATION; INCLUDING LABWORK, TEST RESULTS AND APPOINTMENTS TO THE FOLLOWING INDIVIDUALS:

NAME	RELATIONSHIP	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

NFORMATION MAY BE LEFT ON ANSWERING MACHINE? _____ YES _____ NO

VE WILL NOT PROVIDE ANY MEDICAL INFORMATION TO ANY FAMILY MEMBERS NOT ON THIS LIST VITHOUT A SPECIFIC SIGNED MEDICAL RECORDS RELEASE.

_____ _____
IGNATURE DATE

_____
VITNESS

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PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I,_____ consent to the taking of photographs or videotapes of me or parts of my body, Dr. Phillip Lackey of his designee, in connection with the plastic surgical procedures involving the head and neck, body, or extremities performed by Dr. Lackey and staff.

I understand that such photographs, videotapes or case histories may be pubished by Dr. Lackey in print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and the internet web sites for the purpose of informing the medical profession or the general public about plastic surgery methods.

Neither I, nor any members of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable. I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) years from the date written below.

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Lackey. I understand that the information disclosed, or some portion thereof, may be protected by law and/or the federal Health Insurance Information Portability and Accountability Act of 1996 ("HIPPA").

I release and discharge Dr. Lackey, and all parties acting under his license and authority for all rights that I may have in the photographs, videotapes or case histories and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these materials in any medium.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

Patient_____Date_____

Witness/Physician_____

I have read the above Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.
Parent/Guardian_____Date_____

CHECKLIST: Review of Systems

Checklist:

General-

- ☐ Weight loss or gain
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Weakness
- ☐ Trouble sleeping

Skin-

- ☐ Rashes
- ☐ Lumps
- ☐ Itching
- ☐ Dryness
- ☐ Color changes
- ☐ Hair and nail changes

Head-

- ☐ Headache
- ☐ Head injury

Ears-

- ☐ Decreased hearing
- ☐ Ringing in ears (tinnitus)
- ☐ Earache
- ☐ Drainage

Eyes-

- ☐ Vision
- ☐ Glasses or contacts
- ☐ Pain
- ☐ Redness
- ☐ Blurry or double vision
- ☐ Flashing lights
- ☐ Specks
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Last eye exam

Nose-

- ☐ Stuffiness
- ☐ Discharge
- ☐ Itching
- ☐ Hay fever
- ☐ Nosebleeds
- ☐ Sinus pain

Throat-

- ☐ Teeth
- ☐ Gums
- ☐ Bleeding
- ☐ Dentures
- ☐ Sore tongue
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Thrush
- ☐ Non-healing sores
- ☐ Last dental exam

Neck-

- ☐ Lumps
- ☐ Swollen glands
- ☐ Pain
- ☐ Stiffness

Breasts-

- ☐ Lumps
- ☐ Pain
- ☐ Discharge
- ☐ Self-exams
- ☐ Breast-feeding

Respiratory-

- ☐ Cough (dry or wet, productive)
- ☐ Sputum (color and amount)
- ☐ Coughing up blood (hemoptysis)
- ☐ Shortness of breath (dyspnea)
- ☐ Wheezing
- ☐ Painful breathing

Cardiovascular-

- ☐ Chest pain or discomfort
- ☐ Tightness
- ☐ Palpitations
- ☐ Shortness of breath with activity (dyspnea)
- ☐ Difficulty breathing lying down (orthopnea)
- ☐ Swelling (edema)
- ☐ Sudden awakening from sleep with shortness of breath (Paroxysmal Nocturnal Dyspnea)

Gastrointestinal-

- ☐ Swallowing difficulties
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Nausea
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐Yellow eyes or skin (jaundice)

Urinary-

- ☐ Frequency
- ☐ Urgency
- ☐ Burning or pain
- ☐ Blood in urine (hematuria)
- ☐ Incontinence
- ☐ Change in urinary strength

Genital-

Male-

- ☐ Pain with sex
- ☐ Hernia
- ☐ Penile discharge
- ☐ Sores
- ☐ Masses or pain
- ☐ Erectile dysfunction
- ☐ STD's

Female-

- ☐ Pain with sex
- ☐ Vaginal dryness
- ☐ Hot flashes
- ☐ Vaginal discharge
- ☐ Itching or rash
- ☐ STD's

Vascular-

- ☐ Calf pain with walking (Claudication)
- ☐ Leg cramping

Musculoskeletal-

- ☐ Muscle or joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Trauma

Neurologic-

- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor

Hematologic-

- ☐ Ease of bruising
- ☐ Ease of bleeding

Endocrine-

- ☐ Head or cold intolerance
- ☐ Sweating
- ☐ Frequent urination (polyuria)
- ☐ Thirst (polydypsia)
- ☐ Change in appetite (polyphagia)

Psychiatric-

- ☐ Nervousness
- ☐ Depression
- ☐ Memory loss
- ☐ Stress