Medication Summary Form

David A. Sherris M.D.
1237 Delaware Avenue
Buffalo, New York 14209

Patient Name : _____

Date of Birth : _____

Date : _____

Please list all current prescription and over the counter medications, vitamins or supplements you are taking daily:

Medication :	Dosage :

Please list ALL known drug allergies below:

_____

_____

_____

_____

_____

Clinic of Facial Plastic Surgery
David A. Sherris, M.D.

Patient Name _____ **Visit Date** ___/___/___ **Date of Birth** ___/___/___

Referring Physician / Person _____

Chief Complaint _____

___ Nose ___ Eyes ___ Neck ___ Face ___ Skin

___ Forehead ___ Ears ___ Hair ___ Other: _____

Past History Please explain

___ Previous Surgery _____

___ Allergy to local anesthetics **Yes or No** Explain _____

___ Allergy to Epinephrine **Yes or No** Explain _____

___ Tobacco use **Yes or No** _____ If Yes usage amount _____

___ Difficulty Breathing _____

___ Nasal Congestion _____

___ Facial Trauma _____

___ Skin Cancer _____

___ Thyroid Disorder _____

___ Dry Eyes _____

___ Radiation Therapy: year _____

___ Accutane use: year _____

___ Immune Deficiency: _____

___ Prednisone / Steroid use: year _____

___ Cold Sores _____

Review of Systems Please check all that apply or ____ None

___ Diabetes
___ Headaches
___ Stroke, TIA
___ Fainting
___ Problems with anesthesia
___ Nausea after anesthesia
___ Paralysis
___ Facial Palsy
___ Abnormal Sensation
___ Bleeding Disorder
___ Anemic
___ Easy Bruising
___ Blurred Vision

___ Facial Pain
___ Rash
___ Eczema
___ Dermatitis
___ Anxiety
___ Depression
___ Hepatitis
___ Reflux
___ Heartburn
___ Ulcers
___ Bloody Stool
___ Bloody Vomit
___ Double Vision

___ Hypertension
___ (high blood pressure)
___ Heart Attack
___ Heart Murmur
___ Chest Pain
___ Asthma
___ Shortness of Breath
___ Wheezing
___ Emphysema/COPD
___ Recurrent Chronic Bronchitis
___ Pneumonia
___ Tuberculosis
___ Recent Changes in Vision

___Other Psychiatric problems: _____

Date:_____

Patient Name: _____ **Birth date:**_____ **Age:** _____
First *Middle* *Last*

Address: _____ City: _____ State: _____ Zip:_____

Social Security #: _____ Female □ Male □

Home phone: _____Cell phone: _____ Work phone: _____

Primary Care Physician _____ **Primary Care Phone** _____

Employer: _____ Occupation:_____

Employer address: _____ FT □ PT □ Disabled □

Emergency contact: _____ **Cell phone** _____ **Home phone** _____

Relationship: _____Contact address: _____

Contact Information: May we contact your cell phone? □ Yes □ No **Cell phone:** _____

May we contact you at home? □ Yes □ No

If yes, may we leave a message? □ Yes □ No

May we contact you at work? □ Yes □ No

May we contact you via email? □ Yes □ No Email address: _____

Appointment Confirmation: May we confirm appointments by text message? □ Yes □ No

To confirm by text please provide cell carrier (ATT, Verizon etc.) Carrier: _____

Or we can confirm appointments by e-mail? □ Yes □ No Email: _____

Special Offers and Events: □ I am interested in learning about special events and exclusive offers □ Text □ Email

How did you hear about Dr. Sherris?

□ Website – drsherris.com □ Physician: _____ □ Family/ Friend:_____
Name Name

□ Online search □ Publication:_____ □ Seminar:_____
Name Name

□ Facebook: _____ □ Radio: _____

The Web is an important way for patients to learn about Dr. Sherris and our practice. Please let us know if you use any of the following?

□ Google+ □ Yelp □ Facebook □Twitter □ Pinterest □ RealSelf □ Instagram

□ Medical Review Sites: If yes, which one(s)? _____

□ Blogging: If yes, where can we see it? _____

What website(s) did you find helpful in researching our practice or the procedure? _____

INSURANCE SUBSCRIBER/ HEAD OF HOUSEHOLD- REQUIRED

Name:_____
First Middle Last

Address:_____ City _____State _____Zip Code _____

Home Phone#(_____)_____ Social Security #:_____ **Date of Birth:**___/___/_____

Employer:_____**Work Phone:**_____

Address:_____**Please Circle Status:** FT □ PT □

Your relationship to the insurance subscriber: Self Spouse Child Other_____

INSURANCE INFORMATION: (Please give your insurance cards to the receptionist for verification)

Name Primary Insurance: _____ **ID#** _____

Group #_____ **Effective Date:** _____

Name of Secondary Insurance: _____ **ID#**_____

Group # _____ **Effective Date:** _____

Name of Third Insurance: _____ **ID#** _____

Group # _____ **Effective Date:** _____

Fiscal Policy: All payments for office services are due on the date of service. This would include non-surgical treatments or any insurance co-pay or other insurance financial responsibility. Payment for any cosmetic surgery is required in full 2 weeks or more in advance of scheduled surgery. Insurance financial responsibility is due on any insurance procedures. If you are not aware of your possible insurance responsibility or plan coverage please contact your insurance carrier. Our complete financial policy is available on request.

Cancellation of appointments is required 48 hours prior to scheduled date or service fees may be charged. No Show Fees will be charged for any non-cancelled appointment. Cancellation of any insurance procedure 3 weeks or less prior to surgery will incur a rescheduling fee of $200. Cancellation of any cosmetic procedure for non-medical reasons 2-3 weeks from surgery date will incur a $1000 cancel fee. Less than 2 weeks prior will incur a 25% of surgery fee for non-medical reasons. Cosmetic surgery scheduling deposit of $500 is non-refundable regardless of cancellation date.

Assignment of Benefits: I authorize payment of medical benefits to Dr. David A. Sherris and the release of any medical information to process the payment of any insurance claim.

_____ _____
Signature of Patient or Authorized patient representative Date

_____
Printed Name relationship