THOMAS G. CRABTREE, MD, FACS
BOARD CERTIFIED PLASTIC & RECONSTRUCTIVE SURGEON

Medical History (check one)

Do you smoke, use eCigs, or use any type of tobacco products?

☐ Yes ☐ No

Do you drink alcoholic beverages?

☐ Yes ☐ No

Do you have frequent infections?

☐ Yes ☐ No

Do you form large scars or keloids?

☐ Yes ☐ No

Do you bleed easily from cuts or surgery?

☐ Yes ☐ No

Have you ever had a blood transfusion?

☐ Yes ☐ No

Do you have a history of arthritis?

☐ Yes ☐ No

Are you allergic to Latex?

☐ Yes ☐ No

Have you ever been diagnosed with HIV or Hepatitis?

☐ Yes ☐ No

Do you have a history of Lupus or Connective Tissue Disease?

☐ Yes ☐ No

Are you allergic to any medications? If so please list:

Are you taking any medications? (Please list all prescription and non-prescription drugs):

Do you take Aspirin?

☐ Yes ☐ No

Ibuprofen?

☐ Yes ☐ No

Amount taken daily:

List all past and present medical conditions/surgeries:

I affirm that the above information I have provided is correct to the best of my knowlegdge. It will be held in the strictest of confidence in this office and it will be my responsibility to inform this office of any changes in medical status.

I also authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

I, the patient, and/or responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. I furthermore agree to pay all acceptable co-payments, deductibles, and/or treatment rendered to me or the patient which is not considered to be a covered service by third party insurers or payers.

In the event that I do not have insurance, I understand that all charges are payable the day of service unless payment arrangements have been made in advance with office staff.

Signature of Patient or Guardian

Date