AUTHORIZATION FOR EXAMINATION

Name:	Birthdate:
Address 1:	Social Security Number:
Address 2:	Home Phone:
City: State: Zip:	Work Phone:
Physician: **William G. Loutfy, M.D.**	Cell:
Coordinator:	Chart Number:
Insurance: Yes ( ) No ( )	E-Mail:
	Referred by:

I, ____, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistant or staff as may be assigned by him/her.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. In the event of any litigation arising from treatment, I agree to submit the case to arbitration. I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize that taking of photographs at the direction of my surgeon and under such conditions as may be approved by him/her. These photographs will be used solely for documentation purposes and will be kept confidential.

SIGNATURE:_____________________________________ DATE:____________________________

RELATIONSHIP: (circle one) PATIENT SPOUSE PARENT GUARDIAN

MEDICAL/SURGICAL HISTORY

Patient Name: Today's Date:

Patient No.: Surgery Date:

Surgeon Name: **William G. Loutfy, M.D.**

Procedures:

In this time of rapidly expanding medical knowledge and the increasing specialization associated therewith, there exists a very real risk of the specialist physician not being aware of the general health and medical background of the patient. On occasion such information may critically affect what procedures we may safely undertake on you and under what circumstances. We therefore ask that you give us the following medical information.

Age: Height: Weight: Occupation:

Please list all medications which you are currently taking or have used in the past 6 months (be sure to include any of the following: birth control pills, aspirin or ibuprofen containing drugs, diet pills, diabetic medications, steroids, glaucoma drops, asthma medications, Digoxin, Lanoxin, nitroglycerin, Isordil, Inderal, other heart medications, Lasix, other diuretics, high blood pressure medications, Coumadin, Persantine, tranquilizers, sleeping pills, anti-depressants, pain pills or shots, epilepsy medications, herbs, dietary supplements, non-

Medication(s):	Amount	Frequency

List all drug allergies: Latex allergy? YES/NO

Have you ever used (circle): LSD/speed/cocaine/marijuana? Never

Are you a smoker? YES/NO Ex-Smoker YES/NO Non-Smoker YES/NO

How much are (were) you smoking? How long? Quit how long ago?

How much alcohol do you drink? Caffeine?

Please circle all of the following medical conditions you now have or have had in the past:
bleeding tendency / hepatitis / diabetes / blood transfusions / glaucoma / dry eyes / lung disease / TB / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / heart attack / stroke / epilepsy / heart burn / intestinal ulcers or bleeding / depression / mental illness / drug or alcohol addiction / any other serious illness or injury / None of the above

Is there any possibility that you may be pregnant at this time? YES/NO

List all surgeries that you have had (include plastic surgery): Date:

Have you or anyone in your family ever had unusual reactions to anesthesia (muscle weakness, jaundice, breathing problems or unexpected fevers? YES/NO

Do you have (circle): loose or chipped teeth/caps/dentures/contact lenses/None

Have you ever seen a cardiologist? YES/NO Physician Name:

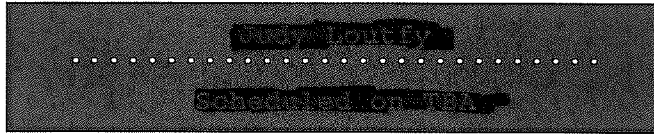
Date of last EKG:

Women:

- Regular self breast exams:
- Number of pregnancies:
- Breast feeding: YES/NO; If yes, when stopped?

Patient's Signature:

Date:



RECEIPT OF PRIVACY PRACTICES*

William Loutfy, M.D.
Albuquerque Center for Plastic Surgery
10400 Academy NE, Suite 230, Albuquerque, NM 87111

I hereby acknowledge that I have received the Notice of Privacy Practices from your office, the practice of William Loutfy, M.D..

Patient signature:

______________________________________ _______________
Date

Printed name of patient:

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William G. Loutfy, M.D.
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(505) 299-4900