COSMETIC & PLASTIC
SURGERY CENTER-TYLER
CRAIG E. HARRISON, M.D.

1100 East Lake St. Suite 200
Tyler, TX 75701
(903) 535-7722
Fax: (903) 535-7878
www.plasticsurgerytyler.com

PATIENT INFORMATION

LAST | FIRST | MI | BIRTHDATE | SOCIAL SECURITY #

MAILING ADDRESS | CITY | STATE | ZIP

HOME PHONE # | CELL PHONE # | E-MAIL ADDRESS

EMPLOYER | WORK #

SEX | MARITAL STATUS | FAMILY PHYSICIAN | REFERRING PHYSICIAN or PERSON

EMERGENCY CONTACT PERSON

LAST | FIRST | RELATION TO PATIENT

HOME PHONE # | WORK PHONE # | CELL #

AUTHORIZATION

I hereby authorize my physician Craig E. Harrison, M.D., to furnish information to insurance carriers, physicians, laboratories, or parties involved in my case. I also assign to my Physician, all payments for medical services rendered if insurance assignment is accepted. I understand that I am financially responsible for all charges. I hereby agree to pay any and all charges that exceed or that are not covered by insurance.

Date X _____ Responsible Party Signature X _____

PHOTO

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MEDICAL HISTORY RECORD

Name _____ Date _____

Height _____ Weight _____ Age _____

Reason for Visit _____ Referred By _____

Date Symptoms First Appeared _____ Family Doctor _____

SOCIAL HISTORY (Please Circle Yes or No)

Yes No Do you smoke or use Tobacco? _____ packs per day
Yes No Did you ever Smoke or use Tobacco?
Yes No Do you drink alcohol? daily_____ occasionally _____

PREVIOUS SURGERIES _____

ANESTHETIC OR SURGICAL PROBLEMS _____

PERSONAL MEDICAL HISTORY (Circle Yes or No)

Yes No High blood pressure
Yes No Heart disease or attack
Yes No Chest pain or shortness of breath
Yes No Stroke
Yes No Asthma
Yes No Glaucoma
Yes No Deep vein thrombosis (blood clot)
Yes No Fainting or blackout episodes
Yes No Ulcer disease or abdominal problems
Yes No Hepatitis
Yes No Diabetes
Yes No Other significant illness Kidney? Thyroid? Seizures?
Sleep Apnea? If so, describe _____

ALLERGIES: Allergic reactions to medications, drugs, or local anesthetic?

MEDICATION	REACTION WHEN TAKEN LAST

CURRENT MEDICATIONS: List all, including aspirin and birth control, herbal medication, and diet pills.

MEDICATION	DOSAGE	MEDICATION	DOSAGE

PATIENT PHARMACY: _____

BLEEDING:

Yes No Have you taken ibuprofen/aspirin in the past two weeks? (Avoid aspirin for two weeks prior to surgery.)
Yes No Do you have prolonged bleeding when cut? (Hemophilia)

SCARRING: Have you formed excessive or unsatisfactory scars in the past? Yes No Keloids?

FAMILY HISTORY (Circle Yes or No)

Yes No Any anesthetic problems? _____
Yes No High blood pressure _____
Yes No Diabetes _____
Yes No Any bleeding problems (Hemophilia)
Yes No Pulmonary Embolus _____
Yes No Deep vein thrombosis (blood clots in legs)
Yes No Hepatitis _____
Yes No Heart Attack _____
Yes No Cancer (Skin) _____
Yes No Other cancers (type) _____
Yes No Psychiatric disorders _____

To my knowledge the above information is complete and accurate.

X_____ (Date)

X_____ (Signature)

Revised 10/20/14

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Patient Name: _____ **Date:** _____ **Date of Birth:** _____

REVIEW OF SYSTEMS

Please (circle) any of the following conditions if they are currently significant:

GENERAL: fever - fatigue - changes in hair - chills - unexplained weight loss

EYES: eye pain - double vision - glaucoma - discharge

EARS: ear pain - drainage - hearing aid: Yes / No - ringing

NOSE: runny nose - congestion - recurrent nose bleeds - sinus infection - do you snore - wake yourself up snoring - feel tired after a good nights sleep.

MOUTH: throat pain - ulcers/sores - difficulty swallowing

CARDIOVASCULAR: chest pain - heart attack - fast/slow heart beat - leg swelling - fainting shortness of breath during the night - pain in calves/thighs when walking

RESPIRATORY: asthma - wheezing - shortness of breath - cough - bloody sputum - hoarseness

GASTROINTESTINAL: diarrhea - constipation - stomach pain - vomiting - indigestion - diet pills nausea - black stools - bright red stools - hemorrhoids - change in bowel habits

GENITOURINARY: pain or burning during urination - blood in urine - urine stream slow to start - incontinence
How many times do you get up to urinate nightly? _____

MUSCULOSKELETAL: extreme backache - pain/numbness - joint pain - joint swelling

NEUROLOGICAL: temporary loss of vision/slurred speech - seizures - loss of balance - loss of coordination - stroke

PSYCHIATRIC: depression - anxiety - mood swings - loss of appetite - suicidal thoughts - sleep disturbance

ENDOCRINE: excessive thirst - excessive hunger - intolerance of heat or cold

HEMATOLOGICAL: swollen lymph glands - easy bruising - bleeding from gums

ALLERGIC: seasonal allergies - food allergies - steroid usage during past year

WOMEN'S HEALTH: (Women Only) last menstrual period: _____ - vaginal discharge
vaginal bleeding after menopause - date last pap smear: _____
breast mass - do not perform regular self breast exam - date last mammogram: _____
nipple discharge
Facility where last mammogram was performed: _____

SKIN: itching - lesions - change in moles

❑ DISCUSSED WITH PATIENT

_____
Physician Signature

Review of Systems

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Patient: _____ **Date:** _____ **Date of Birth:** _____

I have been advised by Dr. Craig Harrison and his staff that I must **not smoke or use tobacco products including nicotine substitutes for a minimum of six (6) weeks before and six (6) weeks after surgery**. Nicotine substitutes include, but are not limited to, patches worn on the body and chewing gum or mints that contain nicotine.

It has been explained to me that the risks of surgery are much greater for smokers and tobacco users, and even if I am off all tobacco products and nicotine substitutes including nicotine gum, nicotine patches, and smokeless tobacco for **six (6) weeks before and six (6) weeks after surgery**, I may still experience the effects of nicotine.

There is also evidence that **second hand smoke** can have detrimental effects on arterial oxygenation and should be avoided. Failure to avoid second hand smoke may increase my risk of post op wound complications.

There is a greater risk in tobacco and nicotine users and people exposed to second hand smoke for bad scarring, hematoma formation, intraoperative bleeding, poor or delayed healing, hair loss, sloughing of the skin (skin loss), infection, increased or prolonged bruising, and hyperpigmentation.

I **ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE INFORMATION ABOVE AND THE RISKS ASSOCIATED WITH TOBACCO USE AND SECOND HAND SMOKE HAVE BEEN FULLY EXPLAINED TO ME.**

Patient Signature: **X**_____ Date: _____

Physician Signature: _____ Witness: _____

Please answer:

1) How long **have** you or **did** you **use** tobacco or nicotine products?_____

2) When did you **last** use a tobacco or nicotine product?_____

3) I am aware of the dangers of **second hand smoke.** _____Initials

Patient Signature: **X**_____ Witness: _____

• • • • • • • • • • • • • • •

(Nicotine users) For follow up purposes: Today's date:_____

1) Patient's last tobacco, nicotine product or nicotine substitute use was_____.

2) Patient's surgery date is _____.

3) Patient promises **not to use tobacco or nicotine in any form** until after_____.

Patient Signature: **X**_____ Witness: _____

Revised 02/27/24

Nicotine Use Risks

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CONSENT TO RECEIVE TEXT MESSAGES AND /OR EMAILS

The office of Dr. Craig Harrison would like to make increasing use of new technology to communicate with patients. We would like to send information via Text Messages and/or E-mails in order to contact our patients regarding appointments or any healthcare services.

If you wish to receive these text messages and /or e-mails, please read the disclaimer and complete and sign the slip below.

Text messages are generated using a secure facility. I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure. However, the practice will not transmit any information which would enable an individual patient to be identified.

TEXT MESSAGE:

The mobile phone number will only be used by the practice in relation to healthcare services and the information will not be passed on to any other parties.

_____YES, I consent to Dr. Craig Harrison and Staff to send me text messages for purpose of appointment reminders or changes.

_____NO, I do not consent to Dr. Craig Harrison and Staff to send me text messages for purpose of appointment reminders or changes.

Mobile Number_____

EMAILS:

The e-mail information will only be sent by the Doctor or Practice Staff and e-mail addresses will not be passed on to any other parties.

_____YES, I consent to Dr. Craig Harrison and Staff to send me e-mails for purpose of appointment reminders or changes.

_____NO, I do not consent to Dr. Craig Harrison and Staff to send me e-mails for purpose of appointment reminders or changes.

E-mail Address_____

_____

_____ _____
Signature Date of Birth

_____ _____
Date Print Name

Revised 10/20/14

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PATIENT PHOTOGRAPH CONSENT FORM

In an effort to give our patient a better understanding of the results that can be achieved, we often use visual aids such as the photographs that were taken of your particular case.

By signing this consent, ❑ you will ❑ will not allow your photographs to be shared by others who have the same or similar procedure/condition. Please understand that your photographs never show faces unless, of course, the face is involved. Our desire is to protect your privacy and so photos would only be available via Touch MD in our office, or on our office computers only. There will be no access beyond our office suite.

X _____
Signature of Patient or Personal Representative

X _____
Date

Date of Birth: _____

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Revised 10/20/14

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Acknowledgement of Privacy Practices

Dear Patient:

You have been given a copy of our Privacy Practice policy. Please complete the statement listed below and sign this acknowledgement. If you have any questions regarding the information set forth in Cosmetic & Plastic Surgery Center - Tyler's Notice of Privacy Practices, please do not hesitate to contact the Privacy Office at 903-596-3388.

I, _____, have received a copy of Cosmetic & Plastic Surgery Center Tyler's notice of privacy practices. I understand that unless I object in writing that my health information can be disclosed for any of the outlined reasons given in the Notice of Privacy Practices.

_____ _____ _____
Signature Date Date of Birth

AUTHORIZATION FOR VERBAL RELEASE OF INFORMATION

Authorization for Use or Disclosure of Information for Cosmetic & Plastic Surgery Center - Tyler

I, _____, hereby authorize Cosmetic & Plastic Surgery Center – Tyler to disclose my protected health information to:

_____
_____
_____

** This protected health information is being used or disclosed for the following purposes: Information directly related to Treatment, Payment and/or Health Care operations. The information may include, but not limited to, medical information, demographics, insurance, date of service, type of service, charges (reasons for denial or patient responsibility), etc.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient Personal Representative

Description of Personal Representative's Authority: _____

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Patient Consent for Use of Credit Cards, Debit Cards and Financing-Disclosure of Protected Health Information

It may become necessary to release your protected health information to financial parties, credit card entities, banks and financing companies when requested to facilitate your payment.

Services performed that are paid for with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Cosmetic & Plastic Surgery Center-Tyler, Craig E. Harrison M.D. P.A. to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment.

Please initial in the spaces provided:

_____I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.

_____I agree that this credit card non challenge agreement is irrevocable.

_____I understand and acknowledge that as the patient, I am the person financially responsible for services, regardless if a third party (or person) may be making payment. (If patient is a minor, parent or guardian must sign and accept all financial responsibilities.)

Date of Birth _____

Patient Printed Name _____ Date_____

Patient Signature _____

Witness_____ Date_____

Revised: 10/20/14