

Kathleen M. Duerksen, M.D., P.C.
Cosmetic and Reconstructive Facial and Eye Plastic Surgery

Welcome to our office. Please fill out this form completely to that we will have information for billing and processing your insurance forms. Thank you.

Name _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip Code _____

Home Phone # _____ Cell # _____ Work Phone# _____

Social Security # _____ Please Circle: Male Female Single Married Widowed Other

May we e-mail you? Yes No E-mail address: _____

Person to Notify in Case of Emergency: _____ Phone # _____

Relationship: _____ Address _____

Referring Doctor Name: _____ Phone # _____

Primary Care Doctor Name: _____ Phone # _____

Employer Name: _____ Phone # _____

Responsible Party Name & Address: _____

Do You Have a Medical Power of Attorney or a Living Will? _____ If yes, may we have a copy? _____

Name of Primary Insurance _____	Name of Secondary Insurance _____
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Address _____	Address _____
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Policyholder Name _____	Policyholder Name _____
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Policyholder Birth Date _____	Policyholder Birth Date _____
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Relationship to Patient _____	Relationship to Patient _____
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Employer _____	Employer _____
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Policy # _____ Group # _____	Policy # _____ Group # _____
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Effective Date _____	Effective Date _____
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REFERRALS: Kathleen M. Duerksen, M.D. is contracted with several insurance carriers, which require appropriate referrals. Obtaining this referral is your responsibility. If seen without the necessary authorizations and referral, you are liable for any charges incurred.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize Kathleen M. Duerksen, M.D. to release medical information requested by insurance companies with which I may have coverage or any public agency which may be assisting in payment of my medical care.

AUTHORIZATION OF INSURANCE BENEFITS: I AUTHORIZE PAYMENT OF BENEFITS. OTHERWISE PAYABLE TO ME, TO BE PAID TO KATHLEEN M. DUERKSEN, M.D., P.C. I understand that I am financially responsible for charges not covered by this assignment. I authorize the refund of overpaid Insurance benefits when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including attorney fees.

This release of medical information and assignment of benefits is considered in force from the date of signing until revoked in writing.

SIGNATURE _____ **DATE** _____

FOR OFFICE USE ONLY: New Patient or Update

Kathleen M. Duerksen, M.D., F.A.C.S.

Medical History

Name: _____ Date: _____

DOB: _____ Height: _____ Weight: _____ Age: _____

Single Married Divorced Widowed

Allergies or reactions to medications	Describe type of reaction (i.e. rash, etc.)

List of current medications, vitamins, supplements, herbs or homeopathic remedies		
Medication	Dose	Frequency taken

Operations, surgeries (including all cosmetic procedures)	Year

Have you or any member of your family had a problem with anesthesia in the past?	Yes	No
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List any health problems you are being treated for

Health Habits	Y	N				
Tobacco products (currently using or in the past)			Years smoked		Packs per day	
			Year quit			
Alcohol			Drinks per day		Drinks per wk	
Recreational drugs			Type:			

Kathleen M. Duerksen, M.D., F.A.C.S.

Name _____

Date _____

Review of Medical Systems

Blood	Y	N	Gastrointestinal	Y	N
Anemia			Hiatal hernia or reflux		
Bruising easily			Problems swallowing		
Blood clots			Ulcers		
Unusual bleeding			Chronic constipation or diarrhea		
Family member with bleeding problem			Irritable bowel syndrome		
Heart (cardiovascular)			Hepatitis		
Heart murmur			Cirrhosis of liver		
Mitral valve prolapse			Nausea or vomiting with anesthesia		
Chest pain (angina)			Urine		
Shortness of breath			Urine retention (difficult passing of urine)		
Swelling of hands or legs			Kidney stones		
Poor circulation			Kidney problems		
Heart palpitations (skipping beats)			Endocrine		
High blood pressure			Diabetes		
High cholesterol			Thyroid disease		
Rheumatic fever			Bones and Joints		
Lungs (pulmonary)			Arthritis		
Asthma			Neck pain, stiffness or poor mobility		
Valley fever			Back pain		
Chronic cough			Fibromyalgia		
Bronchitis			Gynecologic and Breast		
Pneumonia			Number of children		
Shortness of breath			Did you breast feed?		
Nervous system			Breast implants?		
Seizures			Breast surgery?		
Headaches or migraine headaches			Family history of breast cancer?		
Motion sickness			Date of last mammogram:		
Emotional History			Method of birth control:		
Depression			Date of last pap smear:		
Psychiatric care			Are you or could you be pregnant?		
Psychological counseling			Date of last menstrual cycle		
Body dysmorphic syndrome					

If YES to any of the above please explain:

Health Maintenance	
Name of Primary care doctor	
Name of Dermatologist	
Date of last EKG	
Date of last chest X-ray	
Exercise: Type and times per week	

Kathleen M. Duerksen, M.D., F.A.C.S.

Name: _____

Date: _____

SKIN AND HAIR HISTORY

What are your main areas of concern? <input type="checkbox"/> Age spots <input type="checkbox"/> Pustules <input type="checkbox"/> Fine lines <input type="checkbox"/> Scaly patches <input type="checkbox"/> Acne <input type="checkbox"/> Facial Hair <input type="checkbox"/> Red blood vessels <input type="checkbox"/> Pigmentation <input type="checkbox"/> Wrinkles <input type="checkbox"/> Roseacea <input type="checkbox"/> Enlarged pores <input type="checkbox"/> Facial aging <input type="checkbox"/> Blackheads <input type="checkbox"/> Oily skin <input type="checkbox"/> Dry skin <input type="checkbox"/> Sun damaged	Do you wear makeup? <input type="checkbox"/> daily <input type="checkbox"/> occasionally <input type="checkbox"/> never Do you use any of the following? <input type="checkbox"/> Wax for hair removal <input type="checkbox"/> Facials <input type="checkbox"/> Tanning beds Have you had any of the following in the past? <input type="checkbox"/> Botox <input type="checkbox"/> Collagen injections <input type="checkbox"/> Cyst injections <input type="checkbox"/> Acne surgery <input type="checkbox"/> Chemical peels <input type="checkbox"/> Laser resurfacing <input type="checkbox"/> Accutane <input type="checkbox"/> Retin A, Renova, MicroRetin A
Are you currently following a skin care program? Please list product used. Cleanser _____ Toner _____ Moisturizer _____ Sun protection _____ Night treatments _____ Medications _____ Other _____	When do you notice facial wrinkles? <input type="checkbox"/> Never <input type="checkbox"/> Only when smiling <input type="checkbox"/> All the time List all plastic surgery procedures you have undergone. <input type="checkbox"/> Facelift <input type="checkbox"/> Breast Augment <input type="checkbox"/> Liposuction <input type="checkbox"/> Brow lift <input type="checkbox"/> Breast lift <input type="checkbox"/> Tummy tuck <input type="checkbox"/> Eyelift <input type="checkbox"/> Breast reduction <input type="checkbox"/> Lips <input type="checkbox"/> Other:

What is your ethnic background?		
Your Natural coloration:		
Eye Color <input type="checkbox"/> Light blue, gray, light green <input type="checkbox"/> Hazel to blue <input type="checkbox"/> Blue to Green <input type="checkbox"/> Brown <input type="checkbox"/> Dark Brown <input type="checkbox"/> Black	Skin Color <input type="checkbox"/> Very white/freckled <input type="checkbox"/> White <input type="checkbox"/> Olive <input type="checkbox"/> Brown <input type="checkbox"/> Dark brown <input type="checkbox"/> Black	Natural Hair Color <input type="checkbox"/> White blonde/Sandy red <input type="checkbox"/> Blonde <input type="checkbox"/> Auburn <input type="checkbox"/> Light brown or chestnut <input type="checkbox"/> Dark brown <input type="checkbox"/> Black

What best describes your normal sun exposure? <input type="checkbox"/> Never <input type="checkbox"/> Minimal daily (less than 15 minutes) <input type="checkbox"/> Moderate daily (less than 2 hours) <input type="checkbox"/> Significant daily (more than 2 hours) <input type="checkbox"/> Occasional, vacations, weekends only	Do you wear sunscreen or sun block? <input type="checkbox"/> Never <input type="checkbox"/> When outside <input type="checkbox"/> Always
Does your skin tan? <input type="checkbox"/> Never tans and almost always burns <input type="checkbox"/> Rarely tans and usually burns <input type="checkbox"/> Tans and sometimes burns <input type="checkbox"/> Tans well and occasionally burns <input type="checkbox"/> Tans darkly and rarely burns	How long can you be in the sun without protection before burning? <input type="checkbox"/> Less than 15 minutes <input type="checkbox"/> Never Burn <input type="checkbox"/> 15 to 60 minutes <input type="checkbox"/> 1 to 3 hours <input type="checkbox"/> 3 to 6 hours

Please circle if you have or have had any of the following:

Blepharitis	Scar Tissue	Alopecia	Fever Blisters
Dermatitis	Keloids	Blood Thinners	Trichotillomania
HIV	Cold Sores	Hyperpigmentation	Dry Eye Syndrome
Autoimmune Disorders	Shingles	Hypopigmentation	Hemophilia
Eye Disorders	Metal Allergies	Sinusitis	Conjunctivitis
Cosmetic Allergy	Chicken Pox	Allergies To Cosmetics	Bruising
Glaucoma	Collagen	Healing Problems	Chapped Lips

Do you need to take antibiotics prior to see your dentist?	Yes	No
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Kathleen M. Duerksen, M.D.
5979 E. Grant Road, Suite 115
Tucson, AZ 85712-2341
520-751-8030

**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

With my consent, Kathleen M. Duerksen, M.D., may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Kathleen M. Duerksen, M.D., reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Kathleen M. Duerksen, M.D.

With my consent, Dr. Duerksen's office may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the office in carrying out TPO, such as surgery scheduling reminders, insurance or fee items and any call pertaining to my preoperative and postoperative care.

With my consent, Dr. Duerksen's office may mail to my home or other designated locations any items that assist the office in carrying out TPO, such as letters, patient statements and records as long as they are marked Personal and Confidential.

With my consent, Dr. Duerksen's office may fax to me or other designated locations any items that assist the office in carrying out TPO, such as operative reports and patient records. I have the right to request that Dr. Duerksen's office restrict how it uses or discloses my PHI to carry out TPO. However, the office is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Dr. Duerksen's office to use and disclose my PHI to carry out TPO.

With my consent I understand and agree that if I receive an implant, the manufacturer will be provided information if they require this documentation.

I may revoke my consent in writing except to the extent that the office has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Kathleen M. Duerksen, M.D. may decline to provide treatment to me.

Print Patient's Name

Signature of Patient or Legal Guardian

Date