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 _____

Address _____

Policyholder Name _____

Policyholder Birth Date _____

Relationship to Patient _____

Employer _____

Policy #_____ Group #_____

Effective Date _____

Name of
Secondary Insurance_____

Address _____

Policyholder Name _____

Policyholder Birth Date _____

Relationship to Patient _____

Employer _____

Policy # _____ Group # _____

Effective Date _____

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: _____

Height: _____ Weight: _____ Occupation: _____

Health Habits:

Smoke: Currently Y ☐ N ☐
If yes, years smoked: _____
Amount per day: _____
Smoke: Past Y ☐ N ☐
If yes, how long? _____ Year Quit _____

Recreational Drugs: Y ☐ N ☐
If yes, please list type: _____
Cocaine: Y ☐ N ☐
Alcohol: Y ☐ N ☐
Drinks per day _____ drinks per wk_____

ALLERGIES:
Latex Allergy: Y ☐ N ☐ Tape Allergy: Y ☐ N ☐

Exercise: Type and times per week:
_____

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

List any health problems you are being treated for

Health Maintenance	
Name of Primary care doctor	
Name of Dermatologist	
Date of last EKG	
Date of last chest X-ray	

FAMILY HISTORY

Have any close relatives ever had the following problems:
Abnormal bleeding: Y ☐ N ☐ Heart Disease: Y ☐ N ☐
Problems with anesthesia: Y ☐ N ☐ Breast Cancer (mother or sister): Y ☐ N ☐
If yes, please describe problem: _____
_____

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

Name_____ Date_____

PERSONAL PAST HISTORY: Have you ever had:

BLOOD

Anemia:	Y ☐	N ☐
Abnormal clotting (blood clots):	Y ☐	N ☐
Abnormal bleeding:	Y ☐	N ☐
Bruising easily	Y ☐	N ☐

HEART(cardiovascular)

Heart murmur:	Y ☐	N ☐
Mitral valve prolapse:	Y ☐	N ☐
Heart attack:	Y ☐	N ☐
Angina (chest pain):	Y ☐	N ☐
Shortness of breath:	Y ☐	N ☐
Swelling of legs or feet:	Y ☐	N ☐
Poor circulation:	Y ☐	N ☐
Heart palpitations, skipping beats	Y ☐	N ☐
High blood pressure:	Y ☐	N ☐
High cholesterol:	Y ☐	N ☐
Rheumatic fever:	Y ☐	N ☐

LUNGS (Pulmonary)

Asthma:	Y ☐	N ☐
Valley fever:	Y ☐	N ☐
Chronic cough:	Y ☐	N ☐
Bronchitis:	Y ☐	N ☐
Pneumonia:	Y ☐	N ☐
Shortness of breath:	Y ☐	N ☐
Sleep Apnea:	Y ☐	N ☐

NERVOUS SYSTEM

Seizures:	Y ☐	N ☐
Headaches or migraine headaches:	Y ☐	N ☐
Fainting Spell:	Y ☐	N ☐
Motion sickness	Y ☐	N ☐

EMOTIONAL HISTORY

Depression:	Y ☐	N ☐
Psychiatric care:	Y ☐	N ☐
Psychological counseling:	Y ☐	N ☐
Body dysmorphic syndrome:	Y ☐	N ☐

OTHER

Lasik eye surgery:	Y ☐	N ☐
Dry eye syndrome:	Y ☐	N ☐
Eye disorders:	Y ☐	N ☐

INFECTIOUS DISEASE

Aids (HIV)	Y ☐	N ☐
Hepatitis B	Y ☐	N ☐
Hepatitis C	Y ☐	N ☐

GASTROINTESTINAL

Hiatal hernia or reflux:	Y ☐	N ☐
Problems swallowing:	Y ☐	N ☐
Ulcers:	Y ☐	N ☐
Chronic constipation or diarrhea:	Y ☐	N ☐
Irritable bowel syndrome:	Y ☐	N ☐
Hepatitis:	Y ☐	N ☐
Cirrhosis of liver:	Y ☐	N ☐
Nausea or vomiting with anesthesia	Y ☐	N ☐
Weight gain or loss, last 12 months	Y ☐	N ☐
If yes, how much_____		

URINE

Difficult passing of urine:	Y ☐	N ☐
Kidney stones:	Y ☐	N ☐
Kidney problems:	Y ☐	N ☐

ENDOCRINE

Diabetes:	Y ☐	N ☐
Thyroid Disease:	Y ☐	N ☐
Lupus	Y ☐	N ☐

BONES & JOINTS

Arthritis:	Y ☐	N ☐
Neck pain, stiffness, poor mobility	Y ☐	N ☐
Back pain:	Y ☐	N ☐
Fibromyalgia:	Y ☐	N ☐

ANESTHESIA

Motion sickness	Y ☐	N ☐
Nausea or vomiting:	Y ☐	N ☐
Reactions:	Y ☐	N ☐
Please list reaction: _____		

WOMEN: GYNECOLOGIC AND BREAST

Number of pregnancies:	_____	
Number of children:	_____	
Did you breast feed?	Y ☐	N ☐
Method of birth control:	_____	
Breast implants?	Y ☐	N ☐
Breast surgery?	Y ☐	N ☐
History of breast cancer?	Y ☐	N ☐
Date of last mammogram:	_____	
Date of last mammogram:	_____	
Date of last pap smear:	_____	
Are you or could you be pregnant?	Y ☐	N ☐
Date of last menstrual cycle:	_____	

If yes to any of the above please explain: _____

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

Blepharitis	Scar Tissue	Alopecia	Fever Blisters
Dermatitis	Keloids	Blood Thinners	Trichotillomania
Chicken Pox	Cold Sores	Hyperpigmentation	Cosmetic Allergy
Conjunctivis	Shingles	Hypopigmentation	Allergies to Cosmetics
Glaucoma	Metal Allergies	Sinusitis	Hemophilia
Collagen	Healing Problems	Chapped Lips	Autoimmune disorders

Do you need to take antibiotics prior to see your dentist? Yes No

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

SKIN AND HAIR HISTORY

What are your main areas of concern?

___Age spots
___Fine lines
___Acne
___Red blood vessels
___Wrinkles
___Enlarged pores
___Blackheads
___Dry skin
___Pustules
___Scaly patches
___Facial Hair
___Pigmentation
___Roseacea
___Facial aging
___Oily skin
___Sun damaged

Do you wear makeup?

___daily
___occasionally
___never

Do you use any of the following?

___Wax for hair removal
___Facials
___Tanning beds

Have you had any of the following in the past?

___Botox
___Cyst injections
___Chemical peels
___Accutane
___Collagen injections
___Acne surgery
___Laser resurfacing
___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?

___Never
___Only when smiling
___All the time

List all plastic surgery procedures you have undergone.

___Facelift ___Breast Augment ___Liposuction
___Brow lift ___Breast lift ___Tummy tuck
___Eyelift ___Breast reduction
___Lips ___Other:

What is your ethnic background?

Your Natural coloration:

Eye Color

___Light blue, gray, light green
___Hazel to blue
___Blue to Green
___Brown
___Dark Brown
___Black

Skin Color

___Very white/freckled
___White
___Olive
___Brown
___Dark brown
___Black

Natural Hair Color

___White blonde/Sandy red
___Blonde
___Auburn
___Light brown or chestnut
___Dark brown
___Black

What best describes your normal sun exposure?

___Never
___Minimal daily (less than 15 minutes)
___Moderate daily (less than 2 hours)
___Significant daily (more than 2 hours)
___Occasional, vacations, weekends only

Do you wear sunscreen or sun block?

___Never
___When outside
___Always

Does your skin tan?

___Never tans and almost always burns
___Rarely tans and usually burns
___Tans and sometimes burns
___Tans well and occasionally burns
___Tans darkly and rarely burns

How long can you be in the sun without protection before burning?

___Less than 15 minutes ____Never Burn
___15 to 60 minutes
___1 to 3 hours
___3 to 6 hours

I agree that all of the information I have given is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my medical status.

Patient Signature: _____Date _____

MEDICAL STAFF ONLY:
Reviewed By: _____ Date_____

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