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PLASTIC SURGERY

Patient Information

Name: _____ Date of Birth: ___/___/_____ Age: ___
First Middle Last MM DD YYYY

Address: _____
Street City State Zip

Cell Phone: _____ Permission to leave voicemail: ◯ Yes ◯ No
(XXX) XXX-XXXX

Email: _____ Primary Medical Doctor:_____

Ok to send appointment info, specials & communication via encrypted email and text?
◯ Yes ◯ No

Gender: ____ Occupation: _____ Marital Status: _____

How did you hear about us? (Check all that apply)

◯ Google ◯ Facebook ◯ Twitter ◯ Instagram ◯ RealSelf ◯ TikTok _____

Emergency Contact Name & Relationship to Patient: _____
Emergency Contact Cell Phone:_____

Patient History

Height: _____ Weight: _____ Date of Last Physical: ___/___/_____
FT, IN LBS MM DD YYYY

Food/Drug Allergies: _____ Latex Allergy: ◯ Yes ◯ No

Current Medications / Supplements	Dose	Frequency

Former Smoker: ◯ Yes ◯ No Vaping: ◯ Yes ◯ No
Current Smoker: ◯ Yes ◯ No If answered "Yes", number of packs per day: _____

Have you been hospitalized for reasons other than childbirth? ◯ Yes ◯ No

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(919) 797-0996 www.tannanmd.com info@tannanmd.com

Have your any relatives had any problems with anesthesia? ◯ Yes ◯ No

Do you think you may be pregnant? ◯ Yes ◯ No

Number of alcoholic drinks consumed daily: ___ Date of Last Mammogram: ___/___/_____
MM DD YYYY

Past Surgical History

Surgery	Year	Surgeon

Review of Systems

Do you currently have or have you ever had a problem with:

	Y	N
Heart trouble, High blood pressure		
Asthma, lung problems, shortness of breath		
Diabetes		
Liver problems, jaundice, hepatitis		
Chronic headaches		
Neck, leg or back pain		
Breast problems, discharge, breast biopsy, cancer		
Fainting		
Glaucoma		
Cancer		
Bleeding disorders		

	Y	N
Thyroid problems		
Convulsions/seizures		
Kidney Problems		
Skin problems		
Rheumatic fever		
Keloid scars		
Blood clots		
Stomach or intestinal problems		
Psychiatric problems, depression, anxiety		
Lupus, rheumatoid arthritis		
Miscarriages (list how many if yes)		

Please explain any answers marked "Yes" above:

_____

Please list any medical conditions you have: _____

_____

Any family history of significant illness like blood clot, diabetes, heart disease, melanoma, malignant hyperthermia? _____

I certify that the information above is true and correct to the best of my knowledge.

_____ _____ _____

Printed Name Signature Date

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Patient Photograph Release Form

Patient's name _____

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before, during and after procedures. I release and discharge Tannan Plastic Surgery and Shruti C. Tannan, MD, its successors and assigns, and all parties acting under its license and authority, from any and all claims or actions that I have or may have relating to such use and publication and all rights that I may have in such information, photographs, electronic images, video footage and details ("Media") regarding medical services rendered me, including claim for payment in connection with any such user or publication.

I hereby give my consent for Tannan Plastic Surgery to use the Media for the purposes of my medical care with Tannan Plastic Surgery and for in-office photograph albums, print media, broadcast media and electronic media. My consent is subject to the condition that I am not identified by name at any time during any use or publication of these materials.

I certify that I have read the above authorization and release and fully understand its terms.

Patient Signature_____ Date_____

Witness Signature_____

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Acknowledgment of Receipt of Notice of Privacy Practices

I, _____ acknowledge that I have received a copy of Tannan Plastic Surgery's Notice of Privacy Practices. This notice describes how Tannan Plastic Surgery may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____

Signature of Patient Date

Credit Card HIPAA Release

Tannan Plastic Surgery requires a signed release statement from you when a credit card is used to pay for a procedure. If there is ever a dispute with the credit card company regarding this transaction, they will need to have the ability to provide personal information to THAT bank or credit organization.

We value your privacy and will not release any protected health information to the credit card company unless those details are necessary to resolve a dispute.

_____ _____

Patient Signature Date

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Patient Interest List

Welcome to Tannan Plastic Surgery! We are here to restore you to your most confident, brilliant self. Please **select the interests below** that you would like to discuss during your consult today.

- ◯ Botox/Filler
- ◯ Liposuction
- ◯ Breast Augmentation
- ◯ Breast Lift
- ◯ Breast Reduction
- ◯ Breast Reconstruction
- ◯ Tummy Tuck
- ◯ Mommy Makeover
- ◯ Brazilian Butt Lift
- ◯ Microneedling
- ◯ Avéli Cellulite Treatment
- ◯ Submental (Neck) Lipo
- ◯ Labiaplasty
- ◯ Body Contouring
- ◯ Facelift/Necklift
- ◯ Eyelid Surgery
- ◯ Brow Lift
- ◯ Rhinoplasty
- ◯ Lip Filler
- ◯ Fat Grafting
- ◯ Ear Surgery
- ◯ Earlobe Repair
- ◯ Revisionary Facial Surgery
- ◯ Chemical Peel
- ◯ Advanced Skin Care
- ◯ Other: _____

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