

Patient Information

Name:	Date of Birth:	/ /	Age:
First Middle Last	1	MM DD YYYY	′
Address: Street Cit	y Sta	ate	Zip
Cell Phone: Permission to	leave voicemail:	○Yes (No
Email: Primary N	Medical Doctor:		
Ok to send appointment info, specials & communica Yes No	tion via encrypted	d email and te	xt?
Gender: Occupation:	N	Marital Status:	
How did you hear about us? (Check all that apply)			
◯ Google ◯ Facebook ◯ Twitter ◯ Instagram ◯ R	ealSelf (TikTok		
Emergency Contact Name & Relationship to Patient: Emergency Contact Cell Phone:			
Patient History			
Height: Weight: FT, IN LBS	_ Date of Last Ph	nysical:/_ MM DI	/ > YYYY
Food/Drug Allergies:	Latex A	ıllergy: \(\) Ye	es ONo
Current Medications / Supplements	Dose	Fred	quency
Former Smoker: Yes No Vaping: Current Smoker: Yes No If answered	Yes No d "Yes", number o	of packs per da	ay:
Have you been hospitalized for reasons other than c	hildbirth? OYe	s ONo	
Tannan Plastic S	urgery		

2709 Blue Ridge Rd #150, Raleigh, NC 27609

(919) 797-0996





Have your any relatives had any problems v	vith	anes	sthesia?	Yes O No		
Do you think you may be pregnant?	S	\bigcirc I	No			
Number of alcoholic drinks consumed daily	:	_ D	ate of Last M	nammogram: //_ MM DD YY	ΥΥ	
Past Surgical History						
Surgery			Year	Surgeon		
Review of Systems						
Review of Systems						
Do you currently have or have you ever had a n	rabl	am 14	ıi+h.			
Do you currently have or have you ever had a p	IODI	ZIII W	illi.			
	Υ	N			Υ	Ν
Heart trouble, High blood pressure	Ė		Thyroid prol	blems	Ė	
Asthma, lung problems, shortness of breath			Convulsions		+	
Diabetes			Kidney Prob		+-	1
Liver problems, jaundice, hepatitis			Skin probler		+	
Chronic headaches			Rheumatic fever			1
Neck, leg or back pain			Keloid scars			
Breast problems, discharge, breast biopsy, cancer			Blood clots			
Fainting			Stomach or	intestinal problems		
Glaucoma				problems, depression, anxiety		
Cancer			Lupus, rheui	matoid arthritis		
Bleeding disorders			Miscarriage	s (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 bloo hyperthermia?					nt ——	_
I certify that the information above is true and correct to the best of my knowledge.						
Printed Name	Sig	natu	ture 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

may use and disclose my protec	acknowledge that I have received a copy of Tannan ic Surgery's Notice of Privacy Practices. This notice describes how Tannan Plastic Surgery use and disclose my protected health information, certain restrictions on the use and osure of my healthcare information, and rights I may have regarding my protected health mation.		
Signature of Patient		Date	
	Credit Card HIPAA Rele	rase	
to pay for a procedure. If there	is ever a dispute with the cr	From you when a credit card is used edit card company regarding this sonal information to THAT bank or	
We value your privacy and will r company unless those details a	• •	alth information to the credit card oute.	
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.

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

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