

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 _____
------------------------------------	--------------------------------------

Address _____	Address _____
---------------	---------------

Policyholder Name _____	Policyholder Name _____
-------------------------	-------------------------

Policyholder Birth Date _____	Policyholder Birth Date _____
-------------------------------	-------------------------------

Relationship to Patient _____	Relationship to Patient _____
-------------------------------	-------------------------------

Employer _____	Employer _____
----------------	----------------

Policy # _____ Group # _____	Policy # _____ Group # _____
------------------------------	------------------------------

Effective Date _____	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
Conjunctivitis	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 ☐ Pustules ☐ Fine lines ☐ Scaly patches ☐ Acne ☐ Facial Hair ☐ Red blood vessels ☐ Pigmentation ☐ Wrinkles ☐ Roseacea ☐ Enlarged pores ☐ Facial aging ☐ Blackheads ☐ Oily skin ☐ Dry skin ☐ Sun damaged	Do you wear makeup? Do you use any of the following? ☐ daily ☐ Wax for hair removal ☐ occasionally ☐ Facials ☐ never ☐ Tanning beds Have you had any of the following in the past? ☐ Botox ☐ Collagen injections ☐ Cyst injections ☐ Acne surgery ☐ Chemical peels ☐ Laser resurfacing ☐ Accutane ☐ 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