DAVID HOHUAN, MD
FACIAL PLASTIC & RECONSTRUCTIVE SURGERY
HEAD & NECK SURGERY

Otolaryngology-Head and Neck Surgery
Facial Plastic and Reconstructive Surgery
2320 South 22nd Avenue, Yuma AZ 85364
Phone (928) 783-4476, Fax (928) 782-6722

Welcome to our office! Please take a few moments to fill out the information on this page so that we can be of service to you.

Patient Name: (last)_____(first)_____(MI) _____
Parent/Guardian (if minor): _____
Address:_____
City: _____ State:_____ Zip:_____
Birth Date: _____ Age:_____ Marital Status: _____ Sex: M ( ) F ( )
Social Security No.: _____Home Telephone:_____
Occupation: _____Office Telephone:_____E-Mail_____
Employer:_____
Employer Address:_____
Emergency Contact:_____Telephone:_____

Reason for visit:_____

Insurance Co.:_____HMO ( ) PPO ( ) Other:_____

How Did You Learn About Hohuan?

Please check all statements that apply:

_____My friend,_____told me about Dr. Hohuan
_____Dr._____referred me.
_____Your location is convenient to my home or office.
_____I heard Dr. Hohuan speak at _____
_____I wanted to see a Board Certified Facial Plastic Surgeon.
_____I noticed your name in the Yellow Pages, or _____Community Phone Book
_____Hospital referral service:_____
(name of hospital)
Other:_____

*Please list any specific areas or procedures you would like to discuss with Dr. Hohuan:*_____

_____

*What salon/spa do you use?*_____

Authorization to release information and authorization to pay insurance benefits:

I hereby authorize David Hohuan MD PLLC to release medical information to my insurance company or companies. Also by my signature and copies thereof, I authorize payment directly to David Hohuan, MD, PLLC to benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. If my account is turned over to an attorney for collection, I will be responsible for all attorney fees.

Signature:_____ **Date:** _____

MEDICAL HISTORY

Patient Name:_____Date: _____

Primary Care Physician: _____

PCP's office location: _____

Please list allergies to any medications: _____

Please list <u>all</u> of the medications that you take including tablets, capsules, sprays, creams, drops, and vitamins (prescription and over the counter):

_____

_____

_____

Please check all that apply:

☐ High blood pressure	☐ Arthritis	☐ Cancer
☐ Stroke	☐ Endocrine disease	☐ Liver disease
☐ Diabetes	☐ Lung disease	☐ Bleeding disorder
☐ Heart disease	☐ Asthma	☐ Ulcers
☐ Seizure	☐ Mental illness	

☐ Fractures or lacerations of the facial area ☐ Eye problems (including dryness if applicable)

Please list any other current or past medical problems:

_____

_____

Please list any surgeries you have had (with approximate date):

_____

_____

Do you use tobacco? ☐ No ☐ Yes **Aspirin or Ibuprofen?** ☐ No ☐ Yes

Do you drink alcoholic beverages? ☐ No ☐ Yes

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