Otolaryngology-Head and Neck Surgery
Facial Plastic and Reconstructive Surgery
2270 S Ridgeview Drive Suite 128 Yuma, AZ 85364
Phone (928) 723-3004

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 <u>all</u> 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.

David Hohuan, MD PLLC – Patient Medical History

Name: ____ DOB________________ Age: ______
Height: _____ Weight: _______
Best Contact Number: _______________________________________

Please answer the following questions. Your answers are for our medical records only and are confidential.

1. Please list any hospitalizations, operations, significant illnesses, diagnoses, or psychiatric treatment; include childbirth/s (natural, c/section) **with approximate dates**:

____
____
____

2. Have you ever had anesthesia? **Yes / No** (please circle) If so, please describe

____
____

3. Please list any **medications, drugs, or pills** you are currently taking; **include prescription medications, vitamins, enzymes, herbal or homeopathic remedies, etc.** Include any prescription or over the counter skin creams, lotions, etc. Please use reverse side if necessary. (Include prescription dose and frequency)

____
____
____

4. Do you have any **allergies to medications**? **Yes / No** (please circle) **If yes, list medication and describe specific reaction.**

____
____

5. Have you ever had a **fever blister, cold sore, shingles, herpes outbreak**? **Yes / No** (please circle) If yes, how often? Most recent occurrence?

____

6. Do you **smoke or use any nicotine products** of any kind (gum, vaping)? **Yes / No** (please circle) If yes, how much per day?

____

7. Do you have **an allergy to peanuts, soy, eggs, or lates**? **Yes / No** (please circle)
8. Do you drink **alcohol**? **Yes / No** (please circle) How often?

____

9. Do you wear **contact lenses? Yes / No** (please circle)
10. Has there been any change to your general health within the past year? **Yes / No** (please circle) If yes, please describe:

____
____

Please list your physicians' names, telephone numbers, and appointment dates for required pre-operative evaluations

MEDICAL: ____
Doctor's Name Telephone Number Appointment date

OPTICAL: ____
(if applicable) Doctor's Name Telephone Number Appointment date

Patient Signature: ____ Date: ___________