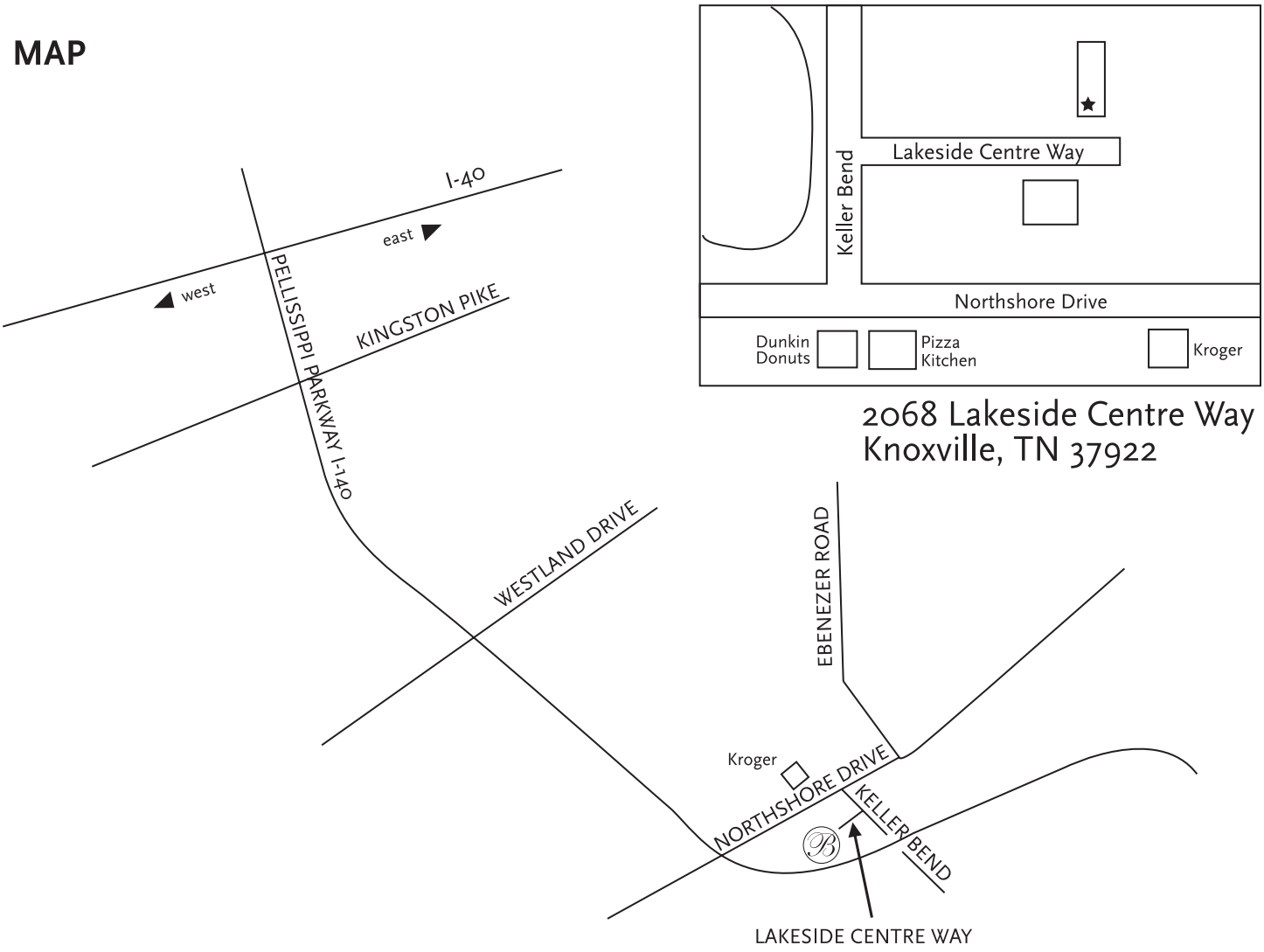
Directions

Heading West on I-40 from downtown Knoxville, take the I-40 E exit (Exit 376B) toward Maryville. Take Exit 5 for Northshore Drive. Turn left onto Northshore Drive heading east. Turn right onto Keller Bend, then right onto Lakeside Centre Way. The Breazeale Clinic is in the first building on the left, Suite 2068.

MAP



2068 Lakeside Centre Way
Knoxville, TN 37922

BreazealeClinic.com

E. Edward Breazeale, Jr., MD, *Board Certified Plastic Surgeon*
2068 Lakeside Centre Way, Knoxville, TN 37922 • 865-342-0300

Chart #_____

Patient's Name _____
First Middle Last

Address _____
Street & Suite # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? □No □Yes May we send promotional text messages? □ No □ Yes

Email Address _____

May we send promotional email messages? □ No □ Yes

Birth Date_____ SS# _____ Gender □ Male □ Female

Marital Status □ Single □ Married to: _____ □ Other

Patient's Employer _____ Occupation _____

Work Phone _____ Ext _____ Is it okay to call you at work? □ Yes □ No

Address _____
Street & Suite # City State Zip

How did you hear about Dr. Breazeale? **(mark all that apply)**

□ TV News □TV ad □ Phone Book □ Magazine □ Newsletter □ Seminar □ Salon □ Web

□ Friend/Relative: _____ □ Doctor: _____ □ Other: _____

If you were referred by a specific person, may we thank them? □ Yes □ No

Emergency Contact (Not in your household)

Name _____ Relationship to Patient _____

Home Phone_____ Work Phone _____ Other Phone_____

Signature _____ Date _____

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History and Physical

Patient's Name: _____ Age: _____

Height: _____ Weight: _____ Number of Children: _____

Part I History

The following questions are to be filled out by the patient. Check box YES or NO. Any positive response will be discussed with you by your doctor.

Lungs	Yes	No
Born with any lung disease	☐	☐
Cough or cold (at present)	☐	☐
Bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Smoke ___ packs of cigarettes per day for the past ____ years.	☐	☐

Heart	Yes	No
Born with any heart disease	☐	☐
Heart murmur	☐	☐
High blood pressure	☐	☐
Skipped heart beats	☐	☐
Chest pain	☐	☐
Hardening of the arteries	☐	☐
Heart failure	☐	☐
Heart attack	☐	☐
Rheumatic fever	☐	☐

Blood	Yes	No
Do bruise or bleed easily	☐	☐
Abnormal bleeding (of any kind) in family	☐	☐
Sickle cell trait/disease	☐	☐
Other blood cell disease	☐	☐
Prolonged bleeding with tooth extraction	☐	☐

Liver	Yes	No
Drink alcoholic beverages	☐	☐
Hepatitis	☐	☐
Jaundice	☐	☐
Other liver disease	☐	☐

Any history of mental illness	☐	☐

Nervous system	Yes	No
Born with abnormality of nervous system	☐	☐
Brain disease	☐	☐
Spinal cord disease	☐	☐
Nerve disease	☐	☐
Epilepsy	☐	☐
Stroke	☐	☐

Endocrine	Yes	No
Diabetes (blood sugar)	☐	☐
Thyroid disorder	☐	☐

Eye	Yes	No
Glaucoma	☐	☐
Contact lenses	☐	☐

Stomach, bowel, gall bladder	Yes	No
Any disease of?	☐	☐

Airway	Yes	No
Problems opening mouth wide	☐	☐
Problems turning head in any direction	☐	☐

Reproductive	Yes	No
Female: Are you pregnant?	☐	☐
Planning preg. preoperatively?	☐	☐
Have you breast fed in the last 3 months?	☐	☐

Musculoskeletal	Yes	No
Any injury or damage to:		
Joints	☐	☐
Tendons	☐	☐
Nerves	☐	☐

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Patient's Name: _____ Date: _____

Do you have any past or present health problems not indicated above? If yes, please describe: _____

_____

_____

Do any diseases run in your family? If so, name the disease: _____

_____

_____

Surgical History:
List previous operations and approximate dates:

_____

_____

_____

Have you ever had complications after surgery?

	YES	NO
Bleeding or blood clot	□	□
Infection	□	□

Other: _____

_____

_____

Anesthetic History:
Date of last general anesthetic: _____
Any problems resulting from any local or general anesthetic ever administered to you?

	YES	NO
Nausea and/or vomiting?	□	□
Any family members with problems related to anesthesia?	□	□

If you answered yes, please explain: _____

_____

_____

_____

Latex Allergy? □ **YES** □ **NO**

Drug Allergies (List):
What kind of reaction?: _____

_____

Who is your primary care physician?

_____

City: _____
Phone number: _____

List ALL present medications: (By name and the reason for taking them). Especially important are: Cortisone, hormones or birth control pills, cold medications, aspirin, or aspirin containing medications, tranquilizers, sedatives, antidepressants, blood thinners (anticoagulants), heart medications, and water pills (diuretics).

_____

_____

_____

_____

_____

	YES	NO
Any history of Arthritis?	□	□

If so, type of Arthritis: _____

If you are taking Arthritis medication, please list:

_____

_____

Name of the physician treating Arthritis:

_____

List any vitamins and/or herbal supplements you are presently taking:

_____

_____

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Patient Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that I am entitled to a hard copy of this information upon my request. In addendum, I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I understand that any change I wish made to this acknowledgement must be done so by me in writing. This includes the addition or deletion of any person or persons I have authorized the release of information to.

Chart #_____

Patient Full Name:_____
(Please Print)

Signature:_____
(Patient or legal guardian. Please specify relationship, if not the patient)

The following individuals have my written consent and permission to speak with The Breazeale Clinic staff regarding my care.

Full Name and Relationship_____

Full Name and Relationship_____

This authorization and acknowledgement expires_____
(If "none" is indicated as the expiration date, you will not be asked to update the form again unless there is a change in the privacy practices, or you amend your authorization)

You have the right to refuse to sign this acknowledgement and authorization. If you refuse, please indicate the reason for refusal:

Payment Policy
Patient Acknowledgment

I have been informed of the $100 consultation fee. I understand that upon scheduling surgery, my fees would be reduced by $100. I understand this fee is non-refundable, even if I elect not to schedule surgery.

I have been informed of the $1000 deposit required to reserve a surgery date. I understand that I will not be placed on the surgery schedule until my deposit has been received. I'm aware that this is a non-refundable deposit. Should I need to reschedule my surgery, my deposit will remain on my account for one year from the original date of deposit. If I should reschedule beyond the one year period, a new deposit would be required.

I am aware that all services performed by Dr. Breazeale are done so as elective, cosmetic and therefore require payment prior to surgery. My final payment will be collected at my preoperative appointment, which is generally scheduled two weeks before my scheduled surgery. If the preoperative appointment should occur less than two weeks from my surgery date, I understand that I will not be permitted to make payment by personal check.

I understand that refunds of surgical fees will be limited by the following schedule:

Cancellation 15 days prior to surgery - $1000
Cancellation 8 to 14 days prior to surgery – The greater of $1000 or 35% of surgery fees
Cancellation 2 to 7 days prior to surgery date – The greater of $1000 or 50% of surgery fees
Cancellation 1 day or less from surgery date – 100% of surgery fees

Patient Name _____ **Date** _____

(Print)

Patient Name _____ **Date** _____

(Signature)

_____

Chart #

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