REGISTRATION FORM – TIM SAYED MD, P.C.

Section 1: Patient Information **Date: _____**

Name: _____ Date of Birth: _____

Address: _____

_____

Email: _____

Home Phone: _____

Cell Phone: _____

Ethnicity: _____ Citizenship: _____

Preferred Language: _____

Social Security Number: _____

Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

If a Minor, School/Grade: _____

Does your job require lifting over 10lbs, reaching overhead, or other strenuous work?

Y / N

Emergency Contact Name and Relationship: _____

_____

Emergency Contact Number: _____

Name of Primary Care Physician: _____

How did you hear about Dr. Sayed? Check all that apply:

❑ Internet Ad	❑ Timsayedmd.com	❑ Facebook	❑ Instagram
❑ Snapchat	❑ Google+	❑ Google Search	❑ Print Ad
❑ Radio Ad	❑ TV Program	❑ Patient	❑ Doctor Referral

Name of Referring Individual or Site: _____

Patient Signature: _____

Section 2: Medical History

Please check all that apply, even if the condition is under control or no longer active:

❑ Anxiety	❑ AIDS/HIV	❑ Breathing Problems
❑ Blood Pressure Problems	❑ Depression	❑ Eye/Vision Problems
❑ Diabetes	❑ Breast Disease	❑ Bleeding Problems
❑ Easy Bruising	❑ Drug Use	❑ Keloids
❑ Scarring Problems	❑ GI Problems	❑ Seizures
❑ Neurologic Conditions	❑ Muscle Weakness	❑ Skin Conditions
❑ Cancer (specify below)	❑ Liver Problems	❑ Bone Disorders
❑ Infectious Diseases (including MRSA or VRE)		❑ Blood Clots
❑ Heart Problems	❑ Heart Attack	❑ Arrhythmia
❑ Palpitations	❑ Hernia	❑ Fracture/Sprain
❑ Orthopedic Conditions	❑ Stroke	❑ Thyroid Disorder
❑ Previous Radiation or Chemotherapy		❑ Endocrine Disease
❑ Vascular Problems/Poor Blood Flow		
❑ Problems with Anesthesia	❑ Family History of Anesthesia Problems	

Please provide details about any of the above here:

_____

_____

_____

_____

Please list any previous plastic/cosmetic/reconstructive surgical procedures:

_____

_____

_____

Allergies (List Medications and Reactions):

_____

_____

Patient Signature: _____

Medications (List All Current Medications and Doses if known):

Review of Systems (Please list any symptoms you've had in the last 2-3 weeks)

- ❑ Fever
- ❑ Cough
- ❑ Chills
- ❑ Headaches
- ❑ Leg Swelling
- ❑ Rashes
- ❑ Wound Drainage
- ❑ Nipple Discharge
- ❑ Abdominal Pain
- ❑ Chest Pain
- ❑ Chills
- ❑ Cold/Flu Symptoms
- ❑ Drug Use
- ❑ Calf Pain/Tenderness
- ❑ Muscle Weakness
- ❑ Changing Mole(s)
- ❑ Breast Pain or Masses
- ❑ Diarrhea
- ❑ Sore Throat
- ❑ Eye/Vision Problems
- ❑ Bleeding
- ❑ Trouble Breathing
- ❑ Pain While Walking
- ❑ Skin Conditions
- ❑ Injuries
- ❑ Back Pain
- ❑ Urinary Tract Symptoms

Family History (Include problems with anesthesia, medical conditions, heart disease, diabetes, blood clots, bleeding problems, lung disease, or other issues affecting siblings, parents, grandparents or children):

Number of Pregnancies: _____ **Live Births:** _____
Date of Last Menstrual Period: _____
Are you pregnant now? Y N **Planning Pregnancy? Y N**
Bra Cup Size and Measurement (if you are considering breast surgery) _____
Target Bra Cup Size _____
Prior Mammogram? Y N **Date:** _____

Number of drinks per week: _____
Do you smoke? **Y N** **Number of cigarettes/day:** _____
If you quit, when did you quit? _____
Drug use? **Y N**

Patient Signature: _____

Have you or a family member ever had a complication of anesthesia? Y N
Provide details:

_____
_____
_____

Section 3: Insurance Information

Name of Insured: _____
SSN of Insured: _____ Relation to Patient: _____
DOB of Insured: _____
Employer Name and Address:
_____
_____
_____
Insurance Company: _____
Insurance Group #: _____ Policy #: _____
Insurance Co. Address: _____
_____
Insurance Co. Phone: _____

Section 4: I am interested in discussing (check all that apply)...

❑ Botox/Dysport	❑ Fillers/Facial Contouring	❑ Thin Lip Augmentation
❑ Buttock Augmentation/BBL	❑ Liposuction/Options	❑ Tummy Tuck
❑ Eyelid Surgery	❑ Face Lift	❑ Brow Lift
❑ Surgery After Weight Loss	❑ Thigh Lift	❑ Arm Lift
❑ Nose Job	❑ Ear Pinning	❑ Scar Revision
❑ Breast Augmentation/Lift	❑ Breast Reduction	❑ Vaginal Rejuvenation
❑ Laser Treatments	❑ Chemical Peels	❑ Facials
❑ Color/Complexion Problems	❑ Moles/Lumps/Bumps	❑ Skin Care/Products

Patient Signature: _____