

DR. MARC LUSSIER, M.D.
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PATIENT INFORMATION

Name: _____ Age: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cellular: _____ e-mail address: _____

Birthdate: _____ S.S.No: _____ Height: _____ Weight: _____

Single: _____ Married: _____ Widowed: _____ Divorced: _____ Occupation: _____

Employed By: _____

Address: _____ City: _____ State: _____ Zip _____

Spouse's Name: _____ S.S.No: _____

Employed By: _____

Address: _____ City: _____ State: _____ Zip _____

Person to Contact in Case of Emergency: _____

Insurance Carrier: _____ Policy #: _____

Subscriber Name: _____ S.S.No: _____

Who referred you to the Doctor? _____ Phone _____

I irreversibly assign to Dr. Marc Lussier all my rights, without limitation, pertaining to my insurance carrier relating to services that Dr. Lussier provided to me. I understand and agree that Dr. Lussier may pursue those rights through demand letters, settlement, and litigation until finished, and that Dr. Lussier will keep all money paid by my insurance carrier. I understand and agree that Dr. Lussier may irreversibly reassign such matters and payments to someone else in order to pursue these matters. I direct my insurance carrier to pay all sums directly to Dr. Lussier or to the party receiving the reassignment.

I, _____, HAVE CAREFULLY READ AND UNDERSTAND THIS ASSIGNMENT, AND ACCEPT, APPROVE, AND AGREE TO THIS ASSIGNMENT.

AUTHORIZED SIGNATURE

DATE

Medical History Questionnaire (Confidential Information)

Patient's Name: _____ Date: _____

Reason for Visit: _____

MEDICAL HISTORY: Please check the following:

High Blood Pressure.....yes ___ no ___

Skin Disease.....yes ___ no ___

Bleeding Disorder.....yes ___ no ___

Thyroid Disease.....yes ___ no ___

Anemia.....yes ___ no ___

Lung Disease.....yes ___ no ___

Liver Disease.....yes ___ no ___

Tuberculosis.....yes ___ no ___

Heart Disease.....yes ___ no ___

Shortness of Breath.....yes ___ no ___

Psychiatric Illness.....yes ___ no ___

Hepatitis.....yes ___ no ___

HIV.....yes ___ no ___

Diabetes.....yes ___ no ___

Please list any other medical history the doctor should be aware of:

Please list any prior hospitalizations below (e.g. accidents, etc.):

FAMILY HISTORY: Please give the age of living or age and cause of death.

Father: _____ Mother: _____

Siblings: _____ Children: _____

MEDICATIONS: Please list medications you currently take, including appetite suppressants, vitamins, herbal supplements, or any homeopathic medication:

Do you take any Aspirin or any Aspirin-containing compound? _____ If "YES," for what reason?

Do you have any ALLERGIES and/or SENSITIVITIES? (please indicate which, if any, are present):

Penicillin.....yes ___ no ___ Aspirin.....yes ___ no ___
Sulfa.....yes ___ no ___ Xylocaine.....yes ___ no ___
Any other Antibiotics.....yes ___ no ___ Adhesive Tape.....yes ___ no ___
Codeine.....yes ___ no ___ Tetanus Toxic.....yes ___ no ___
Any Other.....

SOCIAL HISTORY:

Cigarette Smoking.....yes ___ no ___ How long since last use? _____
Alcohol Use.....yes ___ no ___ Drugs: _____
Caffeine: None: _____ Daily: _____ How much? _____
Do you take Vitamin E? _____ If "YES," how much? _____

SURGICAL HISTORY:

Please list all previous surgeries/operations, as well as cosmetic:

_____ Date _____
_____ Date _____
_____ Date _____

Please list any complications or problems you experienced during or following the above procedures:

Do you wear corrective eye glasses or contacts? _____

Date of last ophthalmology (eye) check up? _____

Have you recently been under the care of a physician for any reason? Yes _____ No _____

If "YES," please explain:

Family Physician: _____ Date of last check up: _____

Address: _____ Phone: _____

Note: If you are scheduled for surgery at any time, please be advised that you cannot take aspirin or aspirin-containing products for a period of two weeks prior to your surgery. Evidence suggests that even small amounts of aspirin or other anti-inflammatory products can create bleeding problems in the apparently healthy adult. Acetaminophen, such as Tylenol, may be used as a substitute for aspirin.