



PATIENT REGISTRATION

Please Print

1011 South Main Street
Hopkinsville, KY 42240

Office: 866-234-0470
Fax: 270-886-3802

Today's Date _____

Patient Name _____ Age _____ Birth Date _____ Sex _____

Address _____

City _____ State _____ Zip _____

Patient's Social Security # _____ Email: _____

Home Phone _____ Work Phone _____ Cell Phone _____

Single Married Divorced Widowed Separated

Employer Name & Address _____ Occupation _____

Parents/Spouse _____ Spouse's Employer _____

(circle)
Family Physician _____

Pharmacy Name _____ Pharmacy Phone _____

Referred By Friend Google Magazine Facebook Physician Other _____

GUARANTOR

Name _____ Relationship to patient _____

Address _____

City _____ State _____ Zip _____ Social Security # _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer Name & Address _____ Active _____ Retired _____

PERSONAL REPRESENTATIVE

Name _____ Relationship _____ Phone _____ Phone _____

Name _____ Relationship _____ Phone _____ Phone _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that Mitchell D. Kaye, M.D., P.S.C., has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of how the practice may use and disclose my protected health information, as well as other rights I have regarding my health information.

Signature of Patient or Personal Representative

Date

CONSENT TO TREATMENT

For all patients:

I voluntarily authorize and consent to the rendering of such care and medical treatment by Mitchell D. Kaye, M.D., and all other authorized agents and employees of Mitchell D. Kaye, M.D., P.S.C. as they may deem necessary or beneficial in their professional judgment. I understand that I have a right to make informed decisions concerning my health care or the health of the persons for whom I am duly authorized to make such decisions. I also acknowledge that no guarantee has been made as to the effect of such examination or treatment of my condition or the condition of the person for whom I am duly authorized to sign. I specifically object to the disclosure of any medical information to the following individuals : _____

Signature of Patient or Personal Representative

PATIENT CONTACT LIST

I am interested in remaining on the patient contact list of Dr. Mitchell Kaye and receiving information on upcoming seminars, new services, newsletters, and other information on cosmetic surgery that might benefit my family or me. YES _____ NO _____

Signature of Patient or Personal Representative - Date



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PATIENT HISTORY

Name: _____ Date: _____ Sex: M F
 Address: _____ Occupation: _____ Age: _____
 _____ Date of Birth: _____ Marital Status: S M W D
 Referred by: _____ Family Medical Doctor _____

Present Illness: (Briefly tell us why you are here today) _____

Allergies: Drugs _____
 Foods _____
 Other (e.g. iodine, etc.) _____

Active Medical Problems? (please circle) High Blood Pressure Heart Problems Diabetes Mellitus
 COPD/Emphysema Asthma Arthritis Stroke Bleeding Problem Cancer Ulcers

List ALL current medications and dosages: _____

Last dose of Aspirin: _____ Last dose of Motrin, Nuprin, Advil, etc. _____

Please list hospitalizations including surgery:

Reason for hospitalization or surgery	Where	When	Physician

Any history of blood transfusions? Yes No When _____

Habits: Do you smoke? Yes No Have you previously smoked? Yes No Year Quit _____
 Number of years _____ Number of packs per day _____
 Do you take two or more drinks of alcoholic beverages a day? Yes No
 How many cups of coffee/tea do you drink each day? _____ How much water do you drink a day? _____
 Have you used street drugs? Yes No
 Do you use seat belts in your car? Yes No
 What physical exercise or sports do you participate in regularly? _____
 What is the highest level of education you have completed? _____

Family History	Age		Cause of Death		Age		Cause of Death
	Live	At Death			Live	At Death	
Father				Husband			
Mother				Wife			
Brother/Sister				Children			
1				1			
2				2			
3				3			

Any family history of the following? (List all parents, grandparents or children with the problem)
 Hypertension Yes No _____ Cancer (specify) Yes No _____
 Heart Disease Yes No _____ Diabetes Mellitus Yes No _____
 Bleeding Disorders Yes No _____ Ear Infections Yes No _____
 Hearing Loss Yes No _____

Do you have a Living Will and/or Advance Directives? Yes No

Patient Signature _____



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MITCHELL D. KAYE, MD, PSC REVIEW OF SYSTEMS

Office: 866-234-0470
Fax: 270-886-3802

Name: _____ Date: _____

Please check boxes of the following for **symptoms now present**.

Constitutional: night sweats unintentional weight loss easy bruising/bleeding
 h/o blood clots/deep vein thrombosis/pulmonary embolus

Skin: previous skin cancers chronic skin problems previous skin surgery other _____
 recent change in a mole (color, bleeding, itching, enlargement) where _____
 h/o cold sores or "fever blisters"

Nose: blocked nose – How long? _____ which side _____ constant? _____
 sinus infection chronic sneezing, itching chronic nasal discharge loss of smell
 previous nose fracture nose bleeds other _____
 nose/sinus surgery _____

Ear: hearing loss – How long? _____ which side _____ constant? _____
 dizziness ear drainage motion sickness
 noise in ears R L Both, sounds like _____ other _____
 ear surgery _____ frequent earaches use Q-tips/bobby pins

Oral/OP: dentures painful/difficult swallowing sore mouth/tongue
 hoarseness recurrent sore throat choking spells
 blood from mouth/throat lump in throat
 snoring mouth breathing stop breathing while asleep/sleep apnea
 lip/mouth/throat surgery _____ other _____

Lymphatic & Neck: enlarged/painful thyroid history of radiation therapy of head & neck
 enlarged/painful salivary glands new lumps in neck
 other _____ previous neck surgery _____

Endocrine: weight loss weight gain diabetes excessive fatigue high blood pressure
 too hot too cold fainting spells hair loss arthritis
 thirst free bleeder excessive nervousness
 other _____ thyroid surgery _____

GI: sour stomach vomiting blood hiatal hernia/reflux abdominal pain
 ulcers other _____ stomach/belly surgery

CV: chest pains stroke heart attack heart surgery
Respiratory: shortness of breath wheezing green/excessive phlegm other _____
 obstructive sleep apnea

NS: severe headache temporary blindness passing out
 numbness seizures weakness of an arm/leg
 suicidal thoughts depression, current excessive anxiety
 difficulty sleeping depression, past history of stroke or TIA

Eyes: wears glasses blurred vision glaucoma double vision
 use eye medications dry eyes other _____ eye surgery in past
 non-seeing, blind eye R L

Gyn/Repro: breast lump/tumor irregular periods Yes No Date of last menstrual period _____
Do you practice birth control: Yes No What type? _____
Any chance of current pregnancy? Yes No
 Mammogram yes no when _____ normal abnormal

Other: List any other medical illnesses _____

If none of the above are applicable, please check here.

PATIENT SIGNATURE