M'LISS HOGAN, M.D.
PLASTIC & RECONSTRUCTIVE SURGERY

215 E. Gibson Street · Covington, LA 70433
(985) 898.1106 · fax (985) 773.1998 · A LIMITED LIABILTY COMPANY

Patient Demographic Information

Last Name	First Name	Middle	Today's Date

Sex	Date of Birth	Social Security #	Driver's License #
☐ Male ☐ Female			

Mailing Address:	May we send information to this address? ☐ Yes ☐ No
Street	
City	State Zip

Home:		May we leave a message at this number? ☐ Yes ☐ No
Cell:		May we leave a message at this number? ☐ Yes ☐ No
Email:		May we email you at this address? ☐ Yes ☐ No
What is your preferred method of contact? (check all that all that apply) ☐ Email ☐ Home ☐ Cell ☐ Text		

Primary Insurance (for non-cosmetic procedures)		Secondary Insurance (for non-cosmetic procedures)	
Subscriber's Name		Subscriber's Name	
Relationship to Patient		Relationship to Patient	
Date of Birth (Subscriber's)		Date of Birth (Subscriber's)	
Social Security #		Social Security #	
Insurance Company		Insurance Company	
ID #		ID #	
Group #		Group #	

Occupation		How did you hear about us?
Employer		☐ Friend/Family:
Employer Phone		☐ Physician:
Emergency Contact Person (relative, or other who we may contact regarding your health information)		☐ Internet
Name		☐ Reputation / Word of mouth
Relationship		☐ Magazine
Phone		☐ Other:

Patient Medical Information

Height:	Current Weight:	Lifetime Highest Weight:

Reason for visit (please check all that apply):

Face	Breast	Body	Non-Surgical & Reconstructive
☐ Face / Neck Lift	☐ Breast Augmentation	☐ Liposuction	☐ Mole Removal
☐ Brow / Forehead Lift	☐ Breast Lift	☐ Tummy Tuck	☐ Scar Revision
☐ Eyelid Enhancement	☐ Breast Reduction	☐ Thigh Lift	☐ BOTOX
☐ Ear Pinning	☐ Breast Reconstruction	☐ Arm Lift	☐ Skin Care
☐ Chin (too large or small)		☐ Buttock/Brazilian Lift	☐ Wrinkles
		☐ Labiaplasty	☐ Skin / Tissue Fillers
		☐ Body Contouring after Weight Loss	☐ Lip Enhancement
☐ Other:	☐ Other:	☐ Other:	☐ Other:

Please check any medical problems:

☐ Hypertension ☐ High Cholesterol ☐ Heart Attack ☐ Stroke ☐ Bleeding Disorders ☐ COPD

☐ Diabetes ☐ Heart Failure ☐ Anemia ☐ Obesity ☐ Cancer ☐ DVT/PE

☐ Other

Please list any previous surgeries:

☐ Gallbladder ☐ Appendectomy ☐ C-section ☐ Hysterectomy ☐ Breast Biopsy ☐ Breast Reduction

☐ Other

Please list any medications with dosage & frequency:

Please list any allergies to mediations and the reaction you had:

Do you smoke: ☐ Yes ☐ No If so, how may packs per day: _____ How many years: _____

Do you drink alcohol: ☐ Yes ☐ No If so, how many drinks per day: _____

Do you use any of the following:

Marijuana ☐ Yes ☐ No If so, how often: _____

Cocaine ☐ Yes ☐ No If so, how often: _____

Other: _____ If so, how often: _____

HAVE YOU EVER HAD:		DO YOU TAKE:	
Uncontrolled bleeding	☐ Yes ☐ No	Birth control pills	☐ Yes ☐ No
Blood clotting issues	☐ Yes ☐ No	Hormone replacement pills	☐ Yes ☐ No
Problems with anesthesia	☐ Yes ☐ No	Fish Oil	☐ Yes ☐ No
Family with anesthesia problems	☐ Yes ☐ No	Aspirin	☐ Yes ☐ No
Heart attack	☐ Yes ☐ No	Ibuprofen (Advil, Motrin)	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Vitamin E	☐ Yes ☐ No
Breast Cancer	☐ Yes ☐ No	Aleve, Naprosyn	☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No	Number of pregnancies: _____	Number of deliveries: _____

Do you now or have you in the past any problems related to the following. PLEASE CHECK ALL THAT APPLY.

Allergic/Immunologic	Constitutional Symptoms	Ears / Nose / Throat	Endocrine
☐ Hay Fever	☐ Chills	☐ Frequent Ear Infections	☐ Diabetes
☐ Lupus	☐ Fever	☐ Frequent Nosebleeds	☐ Excessive Thirst
☐ Scleroderma	☐ Weight Loss - unintended	☐ Sinus problems	☐ Thyroid problems
			☐ Too hot / cold
Genitourinary	**Integument**	**Psychological**	**Respiratory**
☐ Kidney Stones	☐ Boils	☐ Anxiety	☐ COPD
☐ Painful Urination	☐ Keloids / Thick Scars	☐ Bipolar Disorder	☐ Chronic Coughing
☐ Urinary Frequency	☐ Skin Rash	☐ Depression	☐ Pulmonary Embolism
☐ Urinary Retention	☐ Skin Cancer	☐ Schizophrenia	☐ Shortness of Breath
Musculoskeletal	**Neurological**	**Cardiovascular**	**Hematologic / Oncologic**
☐ Arthritis	☐ Alzheimer's	☐ Chest Pain	☐ Bleeding Tendency
☐ Back Pain	☐ Multiple Sclerosis	☐ Heart Murmur	☐ Blood Clotting Problem
☐ Gout	☐ Numbness / Tingling	☐ High Blood Pressure	☐ Hepatitis
☐ Neck Pain	☐ Seizures	☐ Pacemaker	☐ HIV / AIDS
☐ Osteoporosis	☐ Weakness	☐ Heart Attack	☐ Swollen Glands
	Eyes	**Gastrointestinal**	
	☐ Blurred Vision	☐ Abdominal Pain	
	☐ Cataracts	☐ Indigestion / Heartburn	
	☐ Double Vision	☐ Liver Disease	
	☐ Frequent Dry Eyes	☐ Nausea or Vomiting	
	☐ Glaucoma	☐ Special Diet	
	☐ Pain	☐ Stomach Ulcers	

Family Medical History			
Has anyone in your family ever had:			
Uncontrolled bleeding	☐ Yes ☐ No	Problems with anesthesia	☐ Yes ☐ No
Bleeding clotting issues	☐ Yes ☐ No	Malignant Hyperthermia	☐ Yes ☐ No

Breast Consultation Information

Current Bra Size	Desired Bra Size	Height	Weight

Do you smoke? ☐ Yes ☐ No If so, how many packs per day _____ How many years _____

Breast Cancer History

Have you ever had a mammogram? ☐ Yes ☐ No

If so, when was your most recent mammogram:

Date: _____

Facility: _____

Was the mammogram normal? ☐ Yes ☐ No

If abnormal, what was found? _____

Have you had breast cancer? ☐ Yes ☐ No

Any family members with breast cancer? ☐ Yes ☐ No

If so, please list which relative(s):

Relationship: _____

Breast Biopsies? _____ ☐ Yes ☐ No

Age at First Period _____

Pregnancies: #_____ Live Births #_____

Hormone Replacement or Birth Control: _____

FOR OFFICE USE ONLY BELOW THIS LINE

MEASUREMENTS	RIGHT	LEFT
SN-N		
N-IMF		
Base Width		
Estimation of Grams		

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Patient Rights

As a patient, you have the right to:

1. Considerate, respectful care at all times and under all circumstances with recognition of your personal dignity.
2. Personal and informational privacy within the law.
3. Information concerning your diagnosis, treatment, and prognosis, to the degree known; confidentiality of records and disclosures. Except when required by law, you have the right to approve or refuse the release of records.
4. Sale of Private Health Information (PHI) is prohibited.
5. It is the duty of the organization to notify any patient of a breach of unsecured Private health Information (PHI)
6. The Patient has a right to restrict disclosure of PHI where the patient paid "out of pocket".
7. The opportunity to participate in decisions involving your health care unless contraindicated by concerns for your health.
8. Make decisions about medical care including the right to accept or refuse medical or surgical treatment and the right to initiate advance directives such as a living will or durable power of attorney. If you already have a living will or other directive or you wish to initiate one, please speak with a nurse.
9. Information concerning implementation of any advance care directive.
10. Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap or disability. The Center adheres to all federal and state rules, regulations and policies to promote a nondiscriminatory environment for all of our surgical guests.
11. Receive an itemized bill for all services.
12 Know the identity and professional status of individuals providing service to you.
13. Report any comments concerning the quality of services provided to you during the time spent at the facility and receive fair follow-up on your comments.
14. Choose which facility you have your procedure performed.

Patient Responsibilities

As a patient, you are responsible for:

1. Providing to the best of your knowledge accurate and complete information about your present health status and past medical history and reporting any unexpected changes to the appropriate practitioner(s).
2. Following the treatment plan recommended by the primary practitioner involved in your case.
3. Providing for an adult to transport you home after surgery and an adult to be responsible for you at home for the first twenty four (24) hours after surgery.
4. Indicating whether you clearly understand a contemplated course of action and what is expected of you.
5. Your actions if you refuse treatment, leave the facility against the advice of the practitioner, and/or do not follow the practitioner's instructions relating to your care.
6. Assuring that the financial obligations of your health care are fulfilled as expediently as possible.
7. Providing information about and/or copies of any living will, power of attorney or other directive that you desire us to know about.

I have read and understand my rights and responsibilities as a patient of Dr. Hogan

_____ _____

Patient Signature Date

For complaints or grievances please contact:

Tiffany Gremillion
OR
Department of Health & Hospitals
Health Standards Section, P.O. Box 3767
500 Laurel Street, Suite 100
Baton Rouge, LA 70821
225.342.0138