Mitchell D. Kaye, M.D., FACS
Advanced COSMETIC SURGERY Centers of KY & TN

1011 South Main Street
Hopkinsville, KY 42240

919D Tiny Town Road
Clarksville, TN 37042

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

MITCHELL D. KAYE, MD, PSC
PATIENT REGISTRATION
Please Print

Today's Date _____

Patient Name _____ Age _____ Birth Date _____ Sex _____
First Name MI Last Name

Address _____

City _____ State _____ Zip _____

Patient's Social Security # _____ Email: _____

Phone _____ Cell Phone _____ Preference for us to contact you: _____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Employer Name & Address _____ Occupation _____

❑ Parents ❑ Spouse _____ Employer _____
(check one)

Family Physician _____

Pharmacy Name _____ Pharmacy Phone _____

Referred By ❑ Friend ❑ Google ❑ Facebook ❑ Prev. Patient ❑ Radio ❑ Physician ❑ Other _____

GUARANTOR: *Person financially responsible for your account*

Name _____ Relationship to patient _____

Address _____

City _____ State _____ Zip _____ Social Security # _____

Home Phone _____ Work Phone _____ Cell Phone _____

Signature _____

PERSONAL REPRESENTATIVE: *List the person(s) whom you give permission to speak with on your behalf*

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 services. YES ____ NO ____

_____
Signature of Patient or Personal Representative Date

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MITCHELL D. KAYE, MD, PSC
PATIENT HISTORY

Name: _____ Date: _____ Sex: M____ F____TG ____

Address: _____ Occupation: _____ Age: _____

_____ Date of Birth: _____ Marital Status: S__ M__ W__ D__

Referred by: _____ Family Medical Doctor _____

Height:_____ Weight:_____ BMI:_____

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

_____

_____

Allergies: Drugs _____

Foods _____

Other (e.g. iodine, etc.) _____

Active Medical Problems? (please check) High Blood Pressure___ Heart Problems___ Diabetes Mellitus___

Sleep Apnea___ Asthma___ Arthritis___ Stroke___ Bleeding Problem___ Cancer___ Ulcers___

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? _____

What physical exercise or sports do you participate in regularly? _____

What is the highest level of education you have completed? _____

Family History	Age Live	Age At Death	Cause of Death		Age Live	Age At Death	Cause of 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 ___ _____

Heart Disease Yes ___ No ___ _____

Bleeding Disorders Yes ___ No ___ _____

Cancer (specify) Yes ___ No ___ _____

Diabetes Mellitus Yes ___ No ___ _____

Ear Infections Yes ___ No ___ _____

Hearing Loss Yes ___ No ___ _____

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

Patient Signature _____

Form Prepared by Patient

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MITCHELL D. KAYE, MD, PSC
REVIEW OF SYSTEMS

Name:_____ **Date:**_____

Please check 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 of the head & neck(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 ❑ frequent earaches ❑ motion sickness
❑ noise in ears R / L / Both, sounds like _____ ❑ use Q-tips/bobby pins ❑ other_____
❑ ear surgery _____

Oral/OP: ❑ dentures ❑ recurrent sore throat ❑ lump in throat
❑ hoarseness ❑ mouth breathing ❑ stop breathing while asleep
❑ blood from mouth/throat ❑ sore mouth/tongue ❑ Do you have known or suspected Sleep Apnea?
❑ snoring ❑ choking spells ❑ Do you use a CPAP machine?
❑ lip/mouth/throat surgery _____ ❑ other_____
❑ painful/difficult swallowing

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: Respiratory: ❑ chest pains ❑ stroke ❑ heart attack ❑ heart surgery
❑ 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
❑ 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. _____ This information is complete and accurate to the best of my ability.

PATIENT SIGNATURE

Form Prepared By Patient

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