



THE CARNEY CENTER
COSMETIC AND PLASTIC SURGERY

Today's Date: _____ Patient's SS#: _____

Patient's Full Name: _____

Home Phone: _____ Work Phone: _____

E-mail Address: _____ Cell Phone: _____

Date of Birth: _____ Sex: M or F Marital Status: _____

Home Address: _____
Street City State Zip

Mailing Address (if difference from above): _____

Employer: _____ Occupation: _____

Employer Address: _____ Phone Number: _____
(If patient is a minor, parent/guardian to fill in above employment questions and on line below this print your name and relationship to patient)

Your family physician: _____ Your dentist: _____

Other physicians and surgeons: _____

Please tell us how you heard about The Carney Center: _____

If referred by an individual, may we thank this person? _____

Reason for this visit: _____

MEDICAL INSURANCE INFORMATION

If you have coverage and believe that your insurance may cover this visit, please present your card with this form so that a copy may be made and complete the insurance information section below.

Primary Insurance: _____

Cardholder's Name: _____

Cardholder's Date of Birth and Relationship to Patient: _____

Identification Number: _____ Group Number: _____

Secondary Insurance: _____

I hereby authorize release of any information necessary to file a claim with my insurance company. I assign benefits to The Carney Center and will be responsible for balance after insurance payment. A copy of this signature is as valid as the original. In the event of no insurance coverage, I will be responsible for payment of incurred medical expenses.

I do certify that all of the above information is true and correct.

Patient Signature

1868 WILDWOOD DRIVE
VIRGINIA BEACH, VIRGINIA 23454
757/481-4455 FAX 757/481-7808

INTERNET: www.carneycenter.com

Relationship If Not Patient

716 C DENBIGH BOULEVARD
NEWPORT NEWS, VIRGINIA 23608
757/886-9197 FAX 757/877-3143

E-MAIL: drcarney@carneycenter.com

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PATIENT HISTORY

Patient Name: _____ Date: _____

Do you smoke? _____ Cigarettes/day: _____ Health: Excellent Good Fair Poor

Medical allergies: _____

Current medications: _____

Previous surgeries/hospitalizations: _____

Any problems with anesthesia in the past? Y or N If so, what? _____

Any bleeding/bruising problems? _____

Exercise: _____

Hobbies and Interests: _____

Please review the list below and circle any medical conditions you have now or have experienced in the past?

Anemia	Dizziness	Ulcers
Diabetes	Irregular heart beat	High blood pressure
Chest pain	Rheumatic heart disease	Pneumonia
Hepatitis	Cirrhosis	Epilepsy
Cancer	Convulsions	Lumps
Nosebleeds	Glaucoma	Edema (swelling)
Palpitations	Shortness of breath	Gallstones
Stomach bleeding	Leg cramps	Hand problems
Glandular problems	Lupus	Scleroderma
Rheumatoid arthritis	Psychiatric problems	Difficulty urinating
Blood in urine	Herpes	Tuberculosis

Please list any other health problems you may have now or have had in the past which are not mentioned above?

Patient Signature: _____

HOW DID YOU LEARN ABOUT THE CARNEY CENTER?

Please check all statements that apply:

- 1) My friend _____ told me about the Carney Center. _____
- 2) My doctor, _____ M.D. referred me. _____
- 3) Your location is convenient to my home or office. _____
- 4) I was looking for a Board Certified plastic surgeon. _____
- 5) I have seen Dr. Carney on television. _____
- 6) I have seen your homepage on the Internet world wide web. _____
- 7) _____ Hospital recommended Dr. Carney. _____
- 8) I noticed your Yellow Pages ad in _____ directory. _____
- 9) I heard Dr. Carney speak at _____.
- 10) I noticed your ad in the _____ newspaper.
- 11) Other: _____
Other: _____
- 12) Do we have your permission to contact you via e-mail? ____Yes ____No
(To receive special offers, mailers and appointment confirmation.)