

Patrick Hudson MD PA, Front Sheet - form to complete for an initial evaluation

PATIENT QUESTIONS (FRONT PAGE) - PLEASE COMPLETE ALL QUESTIONS AND SIGN PAGE 2

Today's date: \_\_\_\_\_ First name: \_\_\_\_\_ MI: \_\_\_\_\_ Last name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Are you married or have a partner?: YES NO

Street Address: \_\_\_\_\_

City : ABQ Santa Fe other \_\_\_\_\_ State: NM other: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ @ \_\_\_\_\_

Social Security #: \_\_\_\_\_ Cell telephone #: \_\_\_\_\_

Home telephone #: \_\_\_\_\_ Work telephone # : \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Who referred you to our office?

Why are you seeing Dr. Hudson?

Do you suffer from any medication allergies? No Yes (please give details)

Do you take any medications? No Yes (please give details)

Do you take birth control pills or hormones? No Yes (please give details)

Have you ever had any operations? No Yes (please give details)

Do you suffer from any serious illnesses? No Yes (please give details)

Have you ever had bleeding problems? No Yes (please give details)

Have you had difficulty with an anesthetic? No Yes (please give details)

Do you suffer from diabetes? No Yes

Have you ever had a blood clot? No Yes (please give details)

Do you smoke cigarettes? No Yes (how many each day?)

(BACK PAGE)

Patient name: \_\_\_\_\_

**Acknowledgment of receipt of HIPAA information**

I agree that I have been given satisfactory information about HIPAA and my rights and obligations. I have been given an opportunity to review the HIPAA manual of Patrick Hudson MD PA. I have either been given a copy of the *Notice of Privacy Practices* or I refused a copy and reviewed this on the internet at <http://www.e-sthetics.com/>

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_

**Permission to take photographs**

I give permission for Patrick Hudson and his designated assistants to take photographs of me before, during and after my treatment. These photographs may be used for recording my condition and for educational purposes as he sees fit. These photographs may **NOT** be used on the internet without additional permission from me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_

**Permission to use email communication & release information,**

I give permission for Patrick Hudson and his designated assistants to use electronic media, including FAX and/or email to communicate with me and provide information about my case to current, previous and future health care providers, surgery centers, hospitals and insurance companies, and medical loan companies, both during and after my treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_

**LEAVE THIS SECTION FOR DR. HUDSON**

suitable candidate for surgery • Couns • antiDep • antiAnx • SleepMeds • photographs taken