KELAMIS
PLASTIC SURGERY

1792 E Joyce Blvd Suite 1A · Fayetteville, AR 72703 Phone: 479-935-3227 Fax: 833-927-2540

Website: Kelamisplasticsurgery.com

Patient Registration	Today's Date:	
Patient Name:	Gender Identity:	
Preferred Name:	Birth Date:	SS#:
Street Address:	Age:	Marital Status: M S D W Sep
City/State/Zip:	PCP:	
May we send text reminders? Y N May we add you to our email list? Y N	Home Ph :	Cell/Other Ph:
Preferred Method of Contact : Email Home Text Cell	Patient Employer:	

By filling out your email address, I give Dr. Kelamis permission to contact me via email with future communications or scheduling information. Email Address:

Referral Source:

As a referral is a great compliment for a physician, I would like to know how you found my practice, so I can express my gratitude.

__Patient __Word of Mouth	__www.kelamisplasticsurgery.com __Internet	__Physician	Name of Referral (or specific source)

Spouse/Parent Name:	DOB:

Emergency Contact:	Home Ph: ( )
Relationship to patient:	Cell/Other Ph: ( )

Emergency Contact needs to be a person we can contact who does not share the same home phone number.

Primary Insurance:	Insured ID#:
Insured name & relationship to patient:	Insured DOB:
Secondary Insurance:	Insured #: ID
Insured name & relationship to patient:	Insured DOB:

I authorize Kelamis Plastic Surgery PLLC to disclose information concerning medical findings and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Kelamis Plastic Surgery PLLC determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review. I also agree to be responsible for all charges incurred if not covered by my insurance company or other agency. This office agrees to file my insurance claim, if any, providing that my coverage is current and accurate. All co-pays must be paid at the time of service. I authorize release of any medical information necessary to process any claims. I authorize payment of any benefits to Kelamis Plastic Surgery PLLC

Signature:_____ Date:_____

(subscriber, parent, guardian or patient if over 18 years of age)

Medical History	Today's Date:
Patient Name:	Date of Injury/Onset of problem:
Describe the reason for your visit with Dr. Kelamis:	
Current Medications:	Do you take blood thinners or Aspirin? Y N
Preferred Pharmacy:	Phone Number: ( )
Current Vitamins/Supplements:	
Drug Allergies:	Other Allergies:

Social History:

Do you have any children?	Y	N	What ages?	Last Mammogram:	
Do you use alcohol?	Y	N	How much/ how often?	Are you Pregnant/Lactating?	Y N
Do you smoke/use tobacco products?	Y	N	How much/ how often?	Are you going through Menopause?	Y N
Do you use recreational drugs?	Y	N	How much/ how often?		

Previous Surgery:	Type	Year	Hospital	City/State

Choose your Area of Interest

Breast:	Breast Augmentation/ Breast Reconstruction/ Breast Reduction/ Mastopexy(Lift)/ Nipple Reduction or Inversion
Body:	Abdominoplasty(Tummy Tuck)/ Brachioplasty(Arm Lift)/ Liposuction/ Thigh Lift
	Buttock Lift/ Body Lift/ Fat Grafting
Face:	Blepharoplasty/ Botox/ Brow or Forehead Lift/ Earlobe Repair/ Facial Liposuction/Face Lift or Neck Lift
	Lip Enhancement/ Otoplasty(ear pinning)/ Rhinoplasty(Nose)/ Skin Perfecting(LASER)/ Wrinkle Filler or Injectible
Other:	Skin Care/ Telangectasia/ LASER Hair Removal/ Leg Veins/ Lesion or Mole/Wound Repair

	Personal History? If yes, explain.	**Family History?** If yes, which family member(s).
Diabetes	Y N	Y N
Cancer (indicate type)	Y N	Y N
Heart Trouble	Y N	Y N
Seizures	Y N	Y N
High Blood Pressure	Y N	Y N
Bruise/Bleed Easily	Y N	Y N
Blood Clotting Disorders/**DVT/PE**	Y N	Y N
Anxiety	Y N	Check Those Which You Have Had:
Heart Attack	Y N	__Tape Allergy __Depression
Stoke/TIA	Y N	__Latex Sensitive __Psychiatric Care
Keloid Scars	Y N	__Headaches __Chest Pain
Do you object to blood transfusion?	Y N	__Fainting Spells __Blindness
Anemia (low blood counts)	Y N	
Asthma	Y N	
Emphysema	Y N	
Sleep Apnea	Y N	
Depression	Y N	
Bipolar Disorder	Y N	
Hepatitis	Y N	
Autoimmune Disease	Y N	
Weight Gain	Y N	
Weight Loss	Y N	
Other		

Have you had disorder of: __Bones/Joints __Brain/Nerves __Heart/Blood Vessels __Liver __Face __Eyes __Blood
__Reproductive Organs __Urinary System __Intestines/Stomach __Lungs __Ears __Nose __Throat

Why Stop Smoking?

Studies have shown that surgery patients who smoke are 12 times more likely to develop healing problems than non-smokers. In particular, patients who smoke and who have cosmetic surgery, such as breast reductions, tummy tucks, facelifts or other procedures that create skin "flaps," are more prone to healing complications.

The carbon monoxide in cigarette smoke greatly reduces the blood's ability to carry oxygen, which is essential for wound healing. Smoking slows healing, and if a skin "flap" was used, the wound may not heal at all.

Anesthesiologists are responsible for keeping you alive while you are under general anesthesia. Countless studies have shown that smokers have a tendency to develop harsh coughs and an elevated heart rate. **Smoking decreases the proper functioning of the lungs and airways and your body's ability to fight infection. It also affects the blood vessels, the heart, and the blood pressure. Additionally, there is a higher incidence of blood clots in smokers after surgery.**

There are many plastic surgeons who will not even think about performing surgery on a smoking patient. ***Dr. Kelamis has instructed you to cease smoking six weeks prior to and six weeks following surgery.***

If you cannot give up smoking for two weeks before and after the operation, you may want to rethink your decision to have plastic surgery. People choose to have plastic surgery to improve their looks and sense of well-being, so it makes little sense to jeopardize the results by failing to forego smoking for several weeks. If you are a smoker trying to quit, this may be an excellent opportunity to give up the habit altogether.

- **I have read the above information and my signature confirms that I understand that smoking may jeopardize my results and Dr. Kelamis may cancel my surgery.**

Signature: _____ Date: _____