

# INSTITUTE OF PLASTIC SURGERY

KRISHNA S. DASH, M.D.  
Board Certified



RUPESH JAIN, M.D.  
Board Certified

Welcome, and thank you for choosing the Institute of Plastic Surgery

To Whom It May Concern:

Thank you for scheduling with the Institute of Plastic Surgery. We are sending you an appointment slip confirming your scheduled time, and some paper work that will need to be completed and returned to us the day of your appointment. Please take note that if for any reason you are unable to keep the appointment that has been scheduled; we request that you call our office (719) 535-9990 at least 12 hours prior to your scheduled time. This will give the office staff time to move someone else into that consultation slot.

## **Cancellation Policy:**

Out of courtesy our cosmetic consultations are free and with that our physician's schedules fill rapidly. We allow one free rescheduled appointment. If you choose to reschedule your appointment for a second time there will be \$75.00 charge for that consultation. **If you do not cancel your appointment at least 12 hours prior to your scheduled time or you choose to be a "no-show", you will be billed \$75.00 for your missed appointment, and the physician's time spent waiting for you.** Our phone lines are open 24 hours per day and a message can be left at any time if you need to cancel. We pride ourselves with staying on time and getting you back to work or home as soon as possible, so if you're running more than 15 minutes late for the time scheduled we will reschedule that appointment when you come in.

## **Interpreters:**

If you require an Interpreter our office can provide one for you, at a cost to you, of \$40.00 per hour. You are welcome to bring your own, but they will need to be at least 18 years of age and FLUENT in both languages to insure nothing is lost in translation.

## **Insurance related procedures:**

Please call your referring physician or your PCP (primary care physician) to confirm that all referral authorizations for your insurance company have been completed. Bring YOUR current insurance card(s), and be prepared to make your co-payment at the time of your visit. We accept Visa, MasterCard, Discover, cash or check.

## **Do not bring children to your consultation:**

**With all consultation the physicians perform a physical exam and take photos. This takes approximately 45 minutes. Children may not accompany the patient into the exam room and cannot be left unattended in the reception area. Please make other arrangements for your children's supervision.**

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## **Location**

Our office is located at 7606 N. Union Blvd., Ste A, on the corner of Briargate Blvd and Union Blvd. We are located in the Northwest corner of that intersection just behind First Bank. We have enclosed a map and directions; if you need further assistance please call our office.

## **Directions**

From Interstate-25:

Take the Woodmen Exit (#149) and travel east (away from the mountains) for 2 miles. At the Intersection of Union Blvd and Woodmen, take a left (north) and stay in the left hand lane of Union Blvd. The next intersection is Briargate Blvd. Take a left at the light and then an immediate right into the parking lot. You will see the First Bank and the medical offices behind it. We are in the first building on the left, Suite A.

From N. Academy:

Turn on to Briargate Blvd. by the Chapels Hill Mall. Continue up the hill for approximately one mile. On the left hand side of the road, you will see the First Bank. Turn into the parking lot which is located before the light. If you miss the turn, do a u-turn at Union Blvd and make a right into the parking lot.

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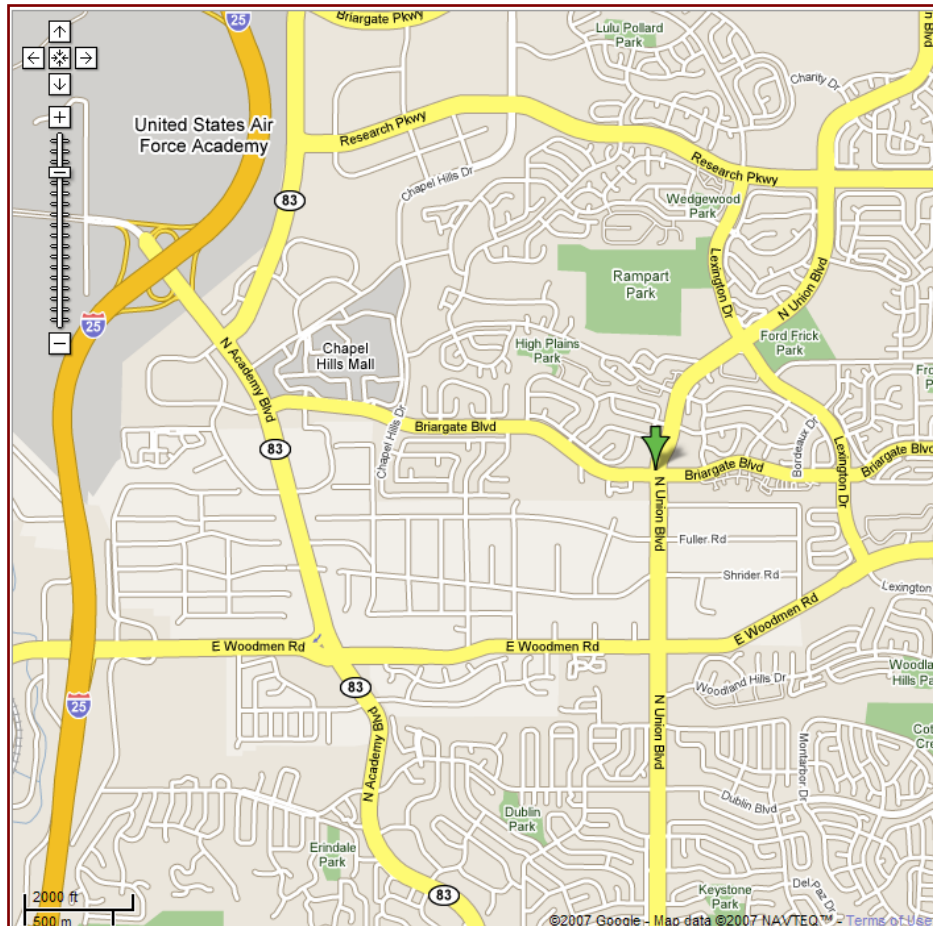
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## Map:



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7606 N. UNION BLVD, SUITE A | COLORADO SPRINGS, CO 80920 | TEL 719.535.9990 | FAX 719.535.9980  
[www.instituteofplastics.com](http://www.instituteofplastics.com)

**WELCOME**  
**INSTITUTE OF PLASTIC SURGERY, P.C.**

7606 N. UNION BLVD, SUITE A | COLORADO SPRINGS, CO 80920 | TEL 719.535.9990 | FAX 719.535.9980

**PATIENT INFORMATION**

Patient \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

May we send letters to this address? \_\_\_\_\_

Sex:  Male  Female Birthdate \_\_\_\_\_

Patient SS# \_\_\_\_\_

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

**PHONE NUMBERS**

**May we call?**

Home \_\_\_\_\_ Y N

Work \_\_\_\_\_ Y N

Cell \_\_\_\_\_ Y N

**HOW DID YOU HEAR ABOUT US?**

Magazine: Connect Colorado  Magazine: Local Value

Friend  Physician

Name \_\_\_\_\_ Name \_\_\_\_\_

Hospital  Yellow Pages: Verizon

Internet  Yellow Pages: DEX

Other \_\_\_\_\_

**WHY ARE YOU HERE?**

- Face Lift
- Brow Lift
- Eyelid Surgery
- Nose Surgery
- Breast Augmentation
- Breast Reduction
- Breast Reconstruction
- Tummy Tuck (Abdominoplasty)
- Liposuction
- Body Contouring (after major weight loss)
- skin care
- skin cancer
- scar revision
- Tissue Fillers
- Botox
- Facial Trauma

Other: \_\_\_\_\_

**MEDICAL HISTORY**

Date of Injury \_\_\_\_\_

Is this a work related issue?  Yes  No

Is there third party liability?  Yes  No

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

Employer's Phone \_\_\_\_\_

**CONTACT IN CASE OF EMERGENCY:**

Name \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Home phone \_\_\_\_\_

Work phone \_\_\_\_\_

**SPOUSE (if different than Emergency contact)**

Spouse's Name \_\_\_\_\_

**INSURANCE**

Who is responsible for the account? \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Co \_\_\_\_\_

ID # \_\_\_\_\_

Group # \_\_\_\_\_

Primary Care Physician? \_\_\_\_\_

Is the patient covered by additional insurance?

Yes  No

Subscriber name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Insurance Co \_\_\_\_\_

Group # \_\_\_\_\_ ID# \_\_\_\_\_

## General Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Last Mammogram \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ / \_\_\_\_\_

Where was the last Mammogram done? \_\_\_\_\_

What is the main reason for you visit today? Please describe in detail. \_\_\_\_\_

Please list any medications along with dosage and frequency? \_\_\_\_\_

Please list any allergies to medications and the reaction to those medications. \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If so, how much and for how long? \_\_\_\_\_

Please list any medical problems. \_\_\_\_\_

Have you had any previous surgeries? Please list with dates. \_\_\_\_\_

Have you had any problems with previous surgeries? \_\_\_\_\_

Do you have a family history of disease or illness (such as heart disease, diabetes, cancer, etc.)? \_\_\_\_\_

Do you now or have you had in the past any problems related to the following. **Please check if Yes.**

### **Allergic/Immunologic**

- Drug Allergies
- Hay Fever
- Lupus
- Scleroderma
- Other \_\_\_\_\_

### **Cardiovascular**

- Chest Pain
- Heart Murmur
- High Blood Pressure
- Pacemaker
- Heart Attack
- Other \_\_\_\_\_

### **Constitutional Symptoms**

- Chills
- Fever
- Weight Loss
- Weight Gain
- Other \_\_\_\_\_

### **Ears/ Nose/ Throat/ Mouth**

- Frequent Ear Infections
- Dental Work
- Nosebleeds
- Sinus problems
- Other \_\_\_\_\_

### **Endocrine**

- Diabetes
- Excessive Thirst
- Thyroid problems
- Tired/Sluggish
- Too hot/cold
- Other \_\_\_\_\_

### **Eyes**

- Blurred Vision
- Cataracts
- Double Vision
- Frequent Dry Eyes
- Glaucoma
- Pain
- Other \_\_\_\_\_

### **Gastrointestinal**

- Abdominal Pain
- Indigestion/ Heartburn
- Liver Disease
- Nausea or Vomiting
- Special Diet
- Stomach Ulcers
- Other \_\_\_\_\_

### **Genitourinary**

- Kidney Stones
- Painful Urination
- Urinary Frequency
- Urinary Retention
- Other \_\_\_\_\_

### **Hematologic/Lymphatic**

- Bleeding Tendency
- Blood Clotting
- Hepatitis
- HIV/AIDS
- Swollen Glands
- Other \_\_\_\_\_

### **Integument**

- Boils
- Keloids/ Thick Scar
- Skin Rash
- Other \_\_\_\_\_

### **Musculoskeletal**

- Arthritis
- Back Pain
- Gout
- Joint Pain
- Neck Pain
- Osteoporosis
- Other \_\_\_\_\_

### **Oncologic (Cancer)**

- Breast Cancer
- Skin Cancer
- Other \_\_\_\_\_

### **Neurological**

- Alzheimer's
- Multiple Sclerosis
- Numbness/ Tingling
- Seizures
- Tremors
- Weakness
- Other \_\_\_\_\_

### **Psychological**

- Anxiety
- Bipolar Disorder
- Depression
- Schizophrenia
- Other \_\_\_\_\_

### **Respiratory**

- COPD
- Chronic Coughing
- Pulmonary Embolism
- Shortness of Breath
- Other \_\_\_\_\_

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## Botox Questionnaire

Name: \_\_\_\_\_

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

Are you pregnant? Y N

Are you nursing? Y N

Have you ever had Botox? Y N

If so, how long ago and by whom? \_\_\_\_\_

Did you have any adverse reactions? \_\_\_\_\_

Do you have any allergies to eggs or albumin? Y N

Do you have any allergies? Y N

\_\_\_\_\_

Do you have any known infection at the proposed areas of injection? Y N

Do you have any known peripheral motor neuropathic/neuromuscular disorders? Y N

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