

**Peter E. Gee M.D. P.C**  
 Plastic and Reconstructive Surgery  
 92 Montvale Avenue – Suite 4650  
 Stoneham, MA 02180  
 Tel: (781) 662-2229 Fax: (781) 662-1811

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Gender \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Partner \_\_\_\_\_

Street Address \_\_\_\_\_ SS# \_\_\_\_\_

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

Home Phone # \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail \_\_\_\_\_

\*\*\*Primary/Family Dr. \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

**How did you hear about us?**

<input type="checkbox"/> My Physician	<i>Full Name:</i>
<input type="checkbox"/> Internet	<i>Name:</i>
<input type="checkbox"/> PRACTICE website	<i>Specify site or search engine:</i>
<input type="checkbox"/> Other	<i>Name:</i>

\*\*\*Reason for seeing Dr. Gee today? \_\_\_\_\_

**Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply.**

<input type="checkbox"/> Skin care advice	<input type="checkbox"/> BOTOX cosmetic	<input type="checkbox"/> Scars (Acne or Surgical)
<input type="checkbox"/> Skin care products	<input type="checkbox"/> Jevederm	<input type="checkbox"/> Sagging skin
<input type="checkbox"/> Breast size or shape	<input type="checkbox"/> Facial fine lines/wrinkles	<input type="checkbox"/> Neck wrinkles
<input type="checkbox"/> Tired looking skin	<input type="checkbox"/> Thin lips	<input type="checkbox"/> Hands: age spots
<input type="checkbox"/> Uneven skin tone	<input type="checkbox"/> Frown lines between brows	<input type="checkbox"/> Abdominal area
<input type="checkbox"/> Skin discoloration	<input type="checkbox"/> Lines around nose & mouth	<input type="checkbox"/> Creases beside mouth or nose
<input type="checkbox"/> Liposuction	<input type="checkbox"/> Dark circles/puffiness in eyes	<input type="checkbox"/> Crows feet (eyes)
<input type="checkbox"/> Rough skin texture	<input type="checkbox"/> Drooping brow	<input type="checkbox"/> Facial Contouring
<input type="checkbox"/> Facial Redness	<input type="checkbox"/> Drooping eyelids	<input type="checkbox"/> Body Skin tightening
<input type="checkbox"/> Brown spots or freckles	<input type="checkbox"/> Nose size or shape	<input type="checkbox"/> Longer, thicker, darker lashes
<input type="checkbox"/> Age spots	<input type="checkbox"/> Facial fullness/drooping	<input type="checkbox"/> Sagging arms
<input type="checkbox"/> Chemical peel	<input type="checkbox"/> Mole removal	<input type="checkbox"/>

Please let us know how we can better serve your needs?

**Maternal History**

Have you ever been pregnant? Yes No If yes, how many times? \_\_\_\_\_  
How many children do you have? \_\_\_\_\_ Are you pregnant now? \_\_\_\_\_

**GENERAL MEDICAL INFORMATION**

Height: \_\_\_\_\_ Present weight: \_\_\_\_\_  
Have you ever smoked? \_\_\_\_\_  
If so how many (packs per day) \_\_\_\_\_ Years smoking: \_\_\_\_\_  
If you are a former smoker, when did you quit? \_\_\_\_\_

Are you allergic to any pills, drugs, and medicine? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please list all:

\_\_\_\_\_

Please list ALL medications you are now taking (including birth control pills, diuretics water pills) blood pressure or heart medications, tranquilizers, hormones, steroid medications, cortisone, blood thinners, aspirin, BUFFERIN, Motrin etc.)

\_\_\_\_\_

Have you ever had a reaction to GENERAL anesthetics? (Being put to sleep) Yes No  
Have you ever had a reaction to a LOCAL anesthetic? (Example Novocain) Yes No  
Do you have high blood pressure? Yes No  
Do you form heavy scars? Yes No  
Do you have frequent infections or boils? Yes No  
Have you ever had any excessive bleeding problems? Yes No  
Have you ever had any significant emotional problems? Yes No  
Have you seen other plastic surgeons about the same problem which brings you here? Yes No  
Date of last breast examination? \_\_\_\_\_  
Have you ever had a mammogram? Yes No  
Date of last of mammogram? \_\_\_\_\_  
Date of last physical exam? \_\_\_\_\_

Have you had any illnesses of the following? (Circle if yes)  
Eyes Breasts Abdomen Bleeding problems Endocrine  
Ears Lungs Urinary Reproduction Other \_\_\_\_\_  
Nose Heart Nervous Extremities

If yes, please explain:

\_\_\_\_\_

**INJURY**

If injury, date \_\_\_\_\_  
Type of injury: Motor Vehicle \_\_\_\_\_ Pedestrian \_\_\_\_\_ Animal Bite \_\_\_\_\_ At work \_\_\_\_\_  
Other \_\_\_\_\_

**PREVIOUS SURGERY**

Operation \_\_\_\_\_ Year \_\_\_\_\_ Complications if any

\_\_\_\_\_

**Peter E. Gee M.D. P.C**  
Plastic and Reconstructive Surgery  
92 Montvale Avenue – Suite 4650  
Stoneham, MA 02180  
Tel: (781) 662-2229

**EXTENDED AUTHORIZATION & CONSENT**

---

Patient's Name	Health Insurance
----------------	------------------

I request that payment under the medical insurance program be made directly to Peter E. Gee, M. D., P.C. on any unpaid bills for services furnished my by:

**Peter E. Gee, M.D., P.C.**

I further authorize any holder of medical or other information about me to be released to the Social Security Administration, its intermediaries or carriers of insurance companies, any information needed for this or a related Medicate or Insurance claims, I permit a copy of this authorization to be used in place of the original. I acknowledge receipt of the Notice of Privacy Practices and I have been provided an opportunity to review it.

---

Signature of Patient	Date
----------------------	------

---

Dear Patient,  
We are here to provide quality health care. However, your insurance company does not cover any service that is not approved, arranged or provided by your Primary Care Physician.

Your signature below indicates that you receive care from Peter E Gee, M.D., P.C. without a referral; you will assume full financial responsibility for the services rendered.

---

Signature of Patient	Date
----------------------	------

