Magnolia Orthopaedics & Sports Medicine Clinic
New Patient

Please print and fill out completely

_____/_____/_____
Today's date

_____ ___/___/__ _____ o M o F _____
Name: First Initial Last **Birthdate:** m/d/yr **Age** **Sex** **Social Security no.**

_____ _____
Home Address City State Zip **Phone:** (area code)

_____ _____
Height **Weight** **Pharmacy Name/Location** **E-mail Address**

Is this a consultation for cosmetic procedures? o Yes o No If not: _____
Insurance coverage

Do you have any medical problems, which require treatment? If so please indicate below.

o Diabetes o Bleeding problems o Cancer o Anemia o Stroke o High blood pressure
o Blood clots o Lung problems o Heart trouble o Heart attacks o Kidney trouble
o Other_____

Please list any prior surgeries:

Surgery	Date	Physician	Hospital	Surgery	Date	Physician	Hospital

Please list all current medications (Include over-the-counter medications) :

Medicine	Dose	Frequency	Medicine	Dose	Frequency
1			2		
3			4		
5			6		
7			8		

List drug allergies: o None o Penicillin o Sulfa o "Mycin" o Aspirin o Codeine o Demerol o Other_____

Do you smoke or use tobacco? o No o Yes,_____packs/day **Do you use alcohol?** o No o Sometimes o Daily

Describe your work: o None _____

Please Indicate health problems, which any of your blood relatives have:

_____

Please Indicate which procedures you are Interested In discussing with Dr. Long:

o Botox o Collagen injections o Face lift o Forehead lift o Eyelid surgery o Laser resurfacing
o Breast lift o Breast enlargement o Liposuction o D Abdominal tightening o Body contouring o Thigh lift
o Arm lift o Lip enlargement o Other_____

_____ _____
James N. Long, M. D. Date

MAGNOLIA ORTHOPAEDICS

O Patient or O Employee
(Please indicate the status of the undersigned)

Consent to Photograph, Video, or Audio Record

The undersigned (Subject) does hereby agree and authorize Magnolia Orthopaedics Operating Entities including Magnolia Regional Health Care and all respective employees, agents, directors, and trustees, hereafter known as "Health System" to photograph, video record, or audio record

_____ while under the care or employment of a UAB Health System facility or clinic for the purposes of patient/staff identification, patient treatment, student/staff education, research, medical journal/publication, marketing by UAB Health System Marketing Communications. Uses for recordings may include but are not limited to; news releases, website content, printed marketing brochures, training/educational videos, or other authorized forms of organizational communication (internal or public) without compensation of any kind. Each communication may also reveal the name and identity of the undersigned in a descriptive text or commentary associated with any recording(s).

The undersigned (Subject) and his or her heirs or next-of-kin do hereby relinquish all rights and privileges to all aforementioned negative(s), print(s), audio recording(s) and/or video recording(s) while relinquishing all current and future rights and in erests for the purposes contemplated herein.

Signed on this the_____Day of_____in the year_____„ at_____:_____am / pm.

_____
Subject or Legal Guardian

_____
Print Name of Subject or Legal Guardian

_____
Witness