PECTUS SERVICES
Providing Pectus Care Since 1996

Business Office:
96 Belmohr St.
Belleville, NJ 07109-2202
877-PECTUS-6 (877-732-8876)

# Pectus Information Profile

**Today's Date: _____ / _____ / 20______**

**Form of Pectus: excavatum / carinatum / combination / flared ribs**

**Patient Name: _________________________________________________ male / female**
First Middle Last

**Address: _________________________________________________________________**

**City: _______________________________________ State: __________ Zip: _________**

**Home Phone: (_____)_______________________ Cell: (_____)_______________________**

**Current Age: _______ Date of Birth: ____/____/_______ _________________________**

**Current School Grade:________________ Dominant Hand: Left / Right**

**Height: ___________ Weight: ___________ Glasses or Contacts: Yes / No**

**Email address: 1)______________________________2)_______________________________**

**Hobbies / Activities / Interests: ___________________________________________________**

**Sports played (if any): ________________________________________________________**

**Primary/Best sport: ___________________________ Position(s): _____________________**

**Any previous injuries / illness / surgery and date: ____________________________________**

**Medical conditions: ___________________________________________________________**

**Medications:_____________________________ Allergies: ____________________________**

**Immunizations up to date? Yes / No / Other: ____________________________________**

**Heart Murmur: Yes / No Heart Problems: ______________________________________**

**Tests done and date: none X-Ray: ____/____/_____ CT / MRI Scan: ____/____/_____**

**EKG: ____/____/____ Echocardiogram: ____/____/____ PFT(breathing): ____/____/____**

**Any important family medical history; brothers or sisters with pectus etc.? Yes / No**

**-If yes please explain:_______________________________________________________**

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**What age did you first notice the Pectus defect?: ______________________________________**

**Is the Pectus defect getting worse? Yes / No / Stayed the same**

**-If Yes over what amount of time have you noticed it getting worse?:**

**6 months 1 year 2 years Other: ____________________________________**

**Reason for seeking pectus help and symptoms experienced: (check all that apply)**

| | | |
|---|---|---|
| **Breathing difficulty** | **Asthma-like symptoms** | **Scoliosis** |
| **Easily winded** | **Embarrassed by chest** | **Slumped shoulders** |
| **Chest pain** | **Avoid swimming** | **Round / bulging belly** |
| **Self esteem** | **Avoid changing in gym** | **Swayback** |
| **Avoid sports** | **Uneven shoulders** | **Forward lurched head** |
| **Flared ribs** | **Never show bare chest** | **Wear clothes to hide it** |

**Attach any photos that may show the timeline of pectus development and dates such as vacation or beach photos. Date them to best of your recollection.**

**Patient marital status: Student Employed Married Single Divorced Separated Widowed**

**Employer: __________________________________________ Occupation:_________________**

## Family Information

**Mother / Step / Guardian's Name: __________________________________________________**

**Marital status: Married Single Divorced Separated Widowed**

**Date of Birth: _____ / _____ / __________**

☐ **Check here if address & phone are same as patient. If not, complete below:**

**Address: ________________________________________________________________________**

**City: _________________________________________ State: ___________ Zip: ____________**

**Home Phone #: (_____)______________________ Cell #: (_____)________________________**

**Email: __________________________________________________________________________**

**Employer: __________________________________________ Occupation:_________________**

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**Father / Step / Guardian's Name**: ______________________________________________

Marital status: Married Single Divorced Separated Widowed

**Date of Birth:** _____ / _____ / __________

☐ **Check here if address & phone are same as patient. If not, complete below:**

**Address:** ______________________________________________________________

**City:** ______________________________________ **State:** __________ **Zip:** ___________

**Home Phone #:** (_____)_____________________ **Cell #:** (_____)_______________________

**Email:** ________________________________________________________________

**Employer:** ________________________________________ **Occupation:**________________

**Other contacts:**

1. **Name:** ____________________________________________________________
   **Relationship:** ______________________________ **Phone #:** (_____)________________
2. **Name:** ____________________________________________________________
   **Relationship:** ______________________________ **Phone #:** (_____)________________

## Guarantor's Information

**Guarantor's Name:** _____________________________________________________

**Guarantor's Relationship to patient:** Parent / Step-Parent / Guardian

☐ **Check here if Guarantor's information is same as above. If not, complete below:**

**Address:** ____________________________________________________________

**City:** ______________________________________ **State:** __________ **Zip:** _________

**Home Phone #:** (_____)____________________ **Cell #:** (_____)______________________

**Email:** ______________________________________________________________

**Employer:** ________________________________________ **Occupation:**_______________

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**Primary Physician Information**

**Primary Physician's Name: ____________________________________________**

**Type of Physician: (circle all that apply)**

**MD DO Pectus Specialist Pediatrician Thoracic Family Other:_______________**

**Address: __________________________________________________________**

**City: ___________________________________ State: _________ Zipcode: _________**

**Phone #: (___)______________________ Fax#: (____)__________________________**

**Referring Physician Information** **(this is the doctor who prescribes the brace)**

☐ **Check here if same as primary physician. If not, complete below:**

**Referring Physician's Name: ____________________________________________**

**Type of Physician: circle all that apply**

**MD DO Pectus Specialist Pediatrician Thoracic Family Other:____________**

**Address: __________________________________________________________**

**City: ___________________________________ State: _________ Zipcode: ________**

**Phone #: (___)______________________ Fax#: (____)_________________________**

**Address:__________________________________________________________**

**City: ___________________________________ State: _________ Zipcode:________**

**Insurance Information** **(include photocopy of front and back of insurance card)**

**Primary Insurance Company:_______________________________________________**

**Subscriber Name:_________________________________ Relationship to patient:_______**

**Policy ID #: ________________________________ Group #:______________________**

**Effective Date & Expiration Date of coverage:____________________________________**

☐ **Check here if there is no secondary insurance coverage. Otherwise, complete below:**

**Secondary Insurance Company:_____________________________________________**

**Subscriber Name:_________________________________ Relationship to patient:_______**

**Policy ID #: ________________________________ Group #:______________________**

**Effective Date & Expiration Date of coverage:____________________________________**

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