Premier Plastic Surgery Center

Patient Information Form

Date:

Patient Name: _____ **Preferred Language:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Cell Phone Carrier:** _____

DOB & Age: _____ **Race:** _____ **Spouses Name:** _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partner

Social Security : _____ **Email Address:** _____

Pharmacy Name: _____ **Pharmacy Address:** _____ **Pharmacy Phone:** _____

Employer Name: _____ **Address:** _____

Occupation: _____ **Work Phone:** _____

How did you hear about us?

☐ TV ☐ Patient Referral: _____ ☐ Internet

☐ Radio ☐ Friend: _____ ☐ Family Member

☐ Google ☐ Dr. Referral: _____ ☐ Real Self

☐ Other: _____ ☐ Website

WHAT IS THE NATURE OF YOUR VISIT?

Emergency Contact

Name: _____ **Relationship:** ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

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Section I:

Please check all that apply regarding your facial complexion. This information is necessary for us to design your skin care program.

Conditions:

o Sun damage	o Upper Lip Lines
o Brown spots	o Freckles
o Wrinkles	o Clogged Pores
o Excessive Oiliness	o Acne
o Pimples	o Dry Patches

What type of skin type do you have? _____Normal to Dry _____Normal to oily

Do you tan? _____Easily _____Burn then tan _____Burn

Any chronic skin or medical disorders? _____Psoriasis _____Fever Blisters _____Hepatitis _____Dermatitis _____ Other

Are you using Retin-A? o Yes o No

Have you used any of the following drugs in the last six months? (If so, check which one(s) apply.)

_____ Accutane _____ Tetracycline _____ . Zovirax _____ Antibiotics oral/topical?

Do you have any facial scarring? o Yes o No Facial region: _____

Have you had or are you planning to have facial surgery? o Yes o No

Have you had any cosmetic peels? _____ Salon _____ TCA _____ Phenol _____ Other _____ Date: _____

Do you wear contacts? o Yes o No

Are you pregnant? o Yes o No o Planning **breast feeding?** o Yes o No **on oral contraceptives?:** o Yes o No
have a hormonal imbalance? o Yes o No

Facial Hair Removal _____ Wax _____ Depilatory _____ Electrolysis _____ Other _____ Date: _____

Please list the products you are currently using and the Brand Names:

Cleanser : _____	Exfoliant: _____
Soap: _____	Night Cream: _____
Mask: _____	Toner: _____
Moisturizer: _____	Other: _____
Eye Cream: _____	Sunscreen: _____

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Section II: Medications

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list with dosages:

_____

_____

_____

_____

_____

Section III: Allergies and Sensitivities

Have you ever been diagnosed with a latex allergy by a physician? ☐ No ☐ Yes If yes when? _____ How were you diagnosed?_____

Have you ever had swelling, itching, hives, redness, irritation wheezing or other symptoms?

After contact with latex or rubber products?	☐ No	☐ Yes
After contact with a balloon?	☐ No	☐ Yes
After an exam or a procedure?	☐ No	☐ Yes
After using diaphragm or condom?	☐ No	☐ Yes
After wearing rubber gloves for one hour?	☐ No	☐ Yes
After wearing elastic or stretch clothing?	☐ No	☐ Yes
Are you allergic to bananas, papaya, avocados, kiwifruits, tomatoes, raw potatoes, chestnuts or poinsettia?	☐ No	☐ Yes
Have you had any unexplained respiratory distress, rapid heart rate, swelling of anaphylactic episodes?	☐ No	☐ Yes

If you answered yes to any of the above please describe below:

_____

Are you allergic to any medications ☐ No ☐ Yes please list with reaction
:_____

_____

Are you allergic to any food? ☐ No ☐ Yes please list:_____

_____

Have you or any family members ever had a serious reaction or complication from anesthesia? ☐ No ☐ Yes please list with reaction:

_____

_____

By signing below, I declare that to the best of my knowledge, the information I have provided is correct and complete.

I understand it is my responsibility to inform my doctor if I have had a change in my health, medications, or allergies.

Patient Signature: _____ *Date:* _____

Clinical Staff Signature: _____ *LATEX ALLERGY NOTED IN CHART* ☐ YES ☐ N/A

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Consent to Communicate / Privacy Policy

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appt Reminders ☐ Email Medical Info ☐ Email Marketing Info ☐ Send Regular Mail ☐ Mail to which address: ☐ Home ☐ Other (please list)				
☐ Text Appt Reminders – if so, list cell carrier:				

I allow the physicians and staff of Premier Plastic Surgery Center and/or Premier Spa to discuss my medical care or finances with the people listed below. This will stay in effect indefinitely.

Name	Relationship	Any Comments

Signature: _____ *Date:* _____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, <PersonalInfo.FirstName> <PersonalInfo.LastName>, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes of office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ *Date:* _____

Premier Plastic Surgery Center

Risk of Personal Information Loss Disclaimer

This is a notice to all of our patients that we use electronic records in this facility as well as some degree of paper charts. We take your privacy and confidentiality very seriously and continue to make all reasonable efforts to insure that no information is lost, compromised, or stolen. All of our employees and service providers (such as our cleaning service) understands and abides by the HIPAA privacy laws. However, in our present world, computer hackers and thieves are becoming more sophisticated and there is no corporation, business, hospital, or even government entity that is not at risk from computer hackers or other thieves stealing valuable information. Therefore, we want to inform you that though we make every effort to secure your confidentiality and privacy, you are assuming some risk when you give out personal information to us or anyone else.

Please initial each of the following statements.

_____ I have been informed that any information I divulge to Premier Plastic Surgery and/or Premier Spa will be either on electronic records or paper files.

____ I have been informed that all the employees and service providers understand and abide by the HIPAA privacy laws.

____ I have been informed that Premier Plastic Surgery Center and Premier Spa will make all reasonable efforts to secure the privacy of my information.

____ I have been informed that as hackers and other "thieves" become more sophisticated, my information could be stolen.

____ By submitting my personal information to Premier Plastic Surgery and/or Premier Spa, I realize that I am assuming some risk of having my information stolen or compromised. Therefore, I release Premier Plastic Surgery Center and/or Premier Spa as well as any employees, agents, officers, and owners, of any and all liability associated with the loss or compromise of my personal information.

____ I have been informed that if my procedure takes place in a hospital or out-patient surgery center, there are added risks to having others view my personal information. For example, any physician or other health care provider with computer access can view virtually any patient records. If I am concerned about this, I will discuss it with the facility to which I am giving out your information. I understand that Premier Plastic Surgery Center and/or Premier Spa have no control or responsibility regarding information I release to any other establishment. I am assuming the risk of releasing my personal information to these other entities.

____ I have been informed that if any of my information has been stolen, I will be notified in a timely fashion.

____ I understand that I should not contact Dr. Ferrari or staff through social media or personal text messages or phone calls with medical concerns. Due to HIPPA Privacy laws, all medical advice must be conducted through our office. If it is not during business hours, I understand that I should call the office and Dr. Ferrari or an on call surgeon will address my needs in a timely fashion.

By signing below, I acknowledge that I have read and understood the above document. I have been given the opportunity to ask questions and have been given the option to not release information to Premier Plastic Surgery and/or Premier Spa. I indemnify and hold harmless any employees, owners, officers, agents of Premier Plastic Surgery Center and Premier Spa with respect to any and all damages resulting from stolen or lost information.

Signature: _____ *Date:* _____