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: ______________ ______________

Occupation: ______________ Work Phone: ____________

How did you hear about us?

☐ TV
☐ Radio
☐ Google
☐ Other: ______________

☐ Patient Referral: ______________
☐ Friend: ______________
☐ Dr. Referral: ______________

☐ Internet
☐ Family Member
☐ Real Self
☐ Website

WHAT IS THE NATURE OF YOUR VISIT?

Emergency Contact

Name: ______________ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: ______________

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Your Visit

In order for us to have a better understanding of your expectations and desires, please answer the following questions.

1) What frustrations do you have that have motivated you to have a procedure(s) performed?

____

2) How long have you been considering having a cosmetic procedure(s)?

____

3) What fears or anxieties have you had about the procedure(s)?

____

4) What changed recently that has made you decide to have your procedure(s) now?

____

5) How soon would you like to have your procedure(s)?

____

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Section I: Health History

Height: ______________________ Weight: ____________________

Check symptoms you currently have or have had in the past year

General

- ☐ Depression/Nervousness
- ☐ Forgetfulness
- ☐ Numbness (where? ________)

Muscle/Joint/Bone

Pain, Weakness, Numbness in

- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

Genito-Urinary

- ☐ Blood in Urine
- ☐ Lack of Bladder Control
- ☐ Painful Urination

Cardiovascular

- ☐ Chest Pain
- ☐ High/Low Blood Pressure
- ☐ Irregular/Rapid Heart Beat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

Eye, Ear, Nose, Throat

- ☐ Blurred Vision
- ☐ Dry Eyes
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Ringing in Ears

Skin

- ☐ Hives
- ☐ Itching/Rash
- ☐ Thick Scars or Keloids
- ☐

Women Only

- ☐ Breast Lump
- ☐ Nipple Discharge

Are you pregnant? ☐ No ☐ Yes

Are you currently nursing? ☐ No ☐ Yes

Check conditions you have or have had in the past

- ☐ AIDS
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding or Clotting Disorders
- ☐ Cancer (Type)__________________
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis: Type ______
- ☐ Herpes (oral or genital?)
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraine Headache
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Other____________

Section II: Surgery and Anesthesia History

1. Please list any medical problems or serious illness (include dates):

____

2. Have you ever had surgery? ☐ No ☐ Yes, please list and include dates:

____

3. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

Section III: Social History

1. Ever smoke or vape? ☐ No ☐ Yes, how much? How many years? Quit? ______________________
2. Do you drink? ☐ No ☐ Yes, how much? ______________________
3. Do you have children? ☐ No ☐ Yes, how many?

Section IIII: Family History

Any blood relatives with significant medical problems? ☐ No ☐ Yes

Description:

____

____

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MRSA

1. Have you been hospitalized in the past year? ☐ No ☐ Yes
2. Have you ever been diagnosed with MRSA ☐ No ☐ Yes If so year diagnosed: ___________________________________
3. Did you receive treatment? ☐ No ☐ Yes 4. Did you have a negative culture following treatment: ☐ No ☐ Yes

Section V: Medications

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

____

____

____

____

____

Section VI: 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

Patient Name:

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:* ______________