

**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

Sex: \_\_\_\_\_ SSN: \_\_\_\_\_ Email Address: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Address: \_\_\_\_\_ Pharmacy Phone Number: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_

How did you hear about us?

<input type="checkbox"/> TV	<input type="checkbox"/> Patient Referral: _____	<input type="checkbox"/> Internet _____
<input type="checkbox"/> Radio	<input type="checkbox"/> Friend: _____	<input type="checkbox"/> Family Member _____
<input type="checkbox"/> Google	<input type="checkbox"/> Dr. Referral: _____	<input type="checkbox"/> Real Self
<input type="checkbox"/> Other: _____		<input type="checkbox"/> 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)?

\_\_\_\_\_

**Section I: Health History**

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

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

<p><b>General</b></p> <p><input type="checkbox"/> Depression/Nervousness</p> <p><input type="checkbox"/> Forgetfulness</p> <p><input type="checkbox"/> Numbness (where? _____)</p> <p><b>Muscle/Joint/Bone</b></p> <p>Pain, Weakness, Numbness in</p> <p><input type="checkbox"/> Arms    <input type="checkbox"/> Hips</p> <p><input type="checkbox"/> Back    <input type="checkbox"/> Legs</p> <p><input type="checkbox"/> Feet    <input type="checkbox"/> Neck</p> <p><input type="checkbox"/> Hands    <input type="checkbox"/> Shoulders</p>	<p><b>Genito-Urinary</b></p> <p><input type="checkbox"/> Blood in Urine</p> <p><input type="checkbox"/> Lack of Bladder Control</p> <p><input type="checkbox"/> Painful Urination</p> <p><b>Cardiovascular</b></p> <p><input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> High/Low Blood Pressure</p> <p><input type="checkbox"/> Irregular/Rapid Heart Beat</p> <p><input type="checkbox"/> Swelling of Ankles</p> <p><input type="checkbox"/> Varicose Veins</p>	<p><b>Eye, Ear, Nose, Throat</b></p> <p><input type="checkbox"/> Blurred Vision</p> <p><input type="checkbox"/> Dry Eyes</p> <p><input type="checkbox"/> Loss of Hearing</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> Ringing in Ears</p>	<p><b>Skin</b></p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Itching/Rash</p> <p><input type="checkbox"/> Thick Scars or Keloids</p> <p><input type="checkbox"/></p> <p style="text-align: center;"><b>Women Only</b></p> <p><input type="checkbox"/> Breast Lump</p> <p><input type="checkbox"/> Nipple Discharge</p> <p>Are you pregnant?</p> <p><input type="checkbox"/> No    <input type="checkbox"/> Yes</p>
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Check conditions you have or have had in the past

<p><input type="checkbox"/> AIDS</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Bleeding or Clotting Disorders</p> <p><input type="checkbox"/> Cancer (Type) _____</p> <p><input type="checkbox"/> Chemical Dependency</p>	<p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> Hepatitis: Type _____</p>	<p><input type="checkbox"/> Herpes (oral or genital?)</p> <p><input type="checkbox"/> High Cholesterol</p> <p><input type="checkbox"/> HIV Positive</p> <p><input type="checkbox"/> Kidney Disease</p> <p><input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> Migraine Headache</p>	<p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Thyroid Problems</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Other _____</p>
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**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:  
\_\_\_\_\_  
\_\_\_\_\_

**Section V: Medications**

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

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**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?  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| After contact with a balloon?   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| After an exam or a procedure?   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| After using diaphragm or condom?  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| After wearing rubber gloves for one hour?   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| After wearing elastic or stretch clothing?  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Are you allergic to bananas, papaya, avocados, kiwifruits, tomatoes, raw potatoes, chestnuts or poinsettia? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Have you had any unexplained respiratory distress, rapid heart rate, swelling or anaphylactic episodes?     | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

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

Are you allergic to any medications or local anesthesia?  No  Yes, please list:

Have you had any unexplained respiratory distress, rapid heart rate, swelling of anaphylactic episodes?

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

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  N/A  Yes

**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*
<input type="checkbox"/> Call Work Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
<input type="checkbox"/> Call Cell Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
<input type="checkbox"/> Call Home Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
<input type="checkbox"/> Send Email			<input type="checkbox"/>	
<input type="checkbox"/> Email Appt Reminders <input type="checkbox"/> Email Medical Info <input type="checkbox"/> Email Marketing Info <input type="checkbox"/> Send Regular Mail <input type="checkbox"/> Mail to which address: <input type="checkbox"/> Home <input type="checkbox"/> Other (please list)				
<input type="checkbox"/> 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](http://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 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: \_\_\_\_\_

**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.

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: \_\_\_\_\_