FACIAL PLASTIC SURGERY ASSOCIATES

GENERAL PATIENT INFORMATION

LAST NAME	FIRST NAME, MIDDLE INITIAL	PREFERRED NAME

May we send information by mail to your home? YES ☐ NO ☐ Do you have an alternate address we may send informtion? YES ☐ NO ☐

MAILING ADDRESS [CITY/STATE/ZIP]	ALTERNATIVE MAILING ADDRESS [CITY/STATE/ZIP]

HOME PHONE	CELL PHONE	OTHER

Preferred number? HOME ☐ CELL ☐ OTHER ☐

EMAIL	AGE	BIRTHDAY

SOCIAL SECURITY NUMBER	GENDER	ETHNICITY	DRIVERS LICENSE NUMBER

MARITAL STATUS	SPOUSE NAME	SPOUSE OCCUPATION & EMPLOYER

PATIENT EMPLOYER	OCCUPATION

WORK ADDRESS	Is it ok to call you at work? YES ☐ NO ☐
	WORK PHONE / EXTENSION

MOTHER'S NAME (IF MINOR)	FATHER'S NAME (IF MINOR)

EMERGENCY CONTACT	RELATIONSHIP

HOME PHONE	CELL PHONE	OTHER

REFERRING PHYSICIAN	PHONE NUMBER	MAILING ADDRESS [CITY/STATE/ZIP]

REFERRAL SOURCE	PHONE NUMBER	MAILING ADDRESS [CITY/STATE/ZIP]

May we thank the person for referring you? YES ☐ NO ☐

NAME

DATE

Thank You for Choosing FPSA

How did you hear about us?

- ☐ INTERNET SEARCH
- ☐ TODAYSFACE.COM
- ☐ TV
- ☐ SALON OR SPA
- ☐ OTHER

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FACIAL PLASTIC SURGERY ASSOCIATES

1. Please specifically give the reason for your visit:

If your reason involves an injury or injuries, please describe the nature and give dates:

2. Please list all drug-related allergies or intolerances (or indicate none).

3. Are you under a doctor's care? YES ☐ NO ☐

NAME OF PHYSICIAN | PHONE

ADDRESS [CITY/STATE/ZIP]

Date of last complete physical examination?

4. Have you ever seen an allergist? YES ☐ NO ☐

NAME OF ALLERGIST

5. List all medications you are currently taking, along with the dosage and frequency:
(including over the counter medicines, aspirin or medicines containing aspirin, birth control pills, diet pills, Vitamin E, or herbal preparations)

6. List all previous operations or major illnesses and all hospitalizations you have had, along with dates.

7. Have you had a Botox Injection? YES ☐ NO ☐

WHEN | WHERE

FAMILY HISTORY

Alcoholism	YES ☐ NO ☐	High Blood Pressure	YES ☐ NO ☐	Diabetes	YES ☐ NO ☐
Family Estrangements	YES ☐ NO ☐	Cancer	YES ☐ NO ☐	Strokes	YES ☐ NO ☐
Allergies	YES ☐ NO ☐	Nervous Breakdown	YES ☐ NO ☐	Epilepsy	YES ☐ NO ☐
Heart Attacks	YES ☐ NO ☐	Congenital Defects	YES ☐ NO ☐	Suicide	YES ☐ NO ☐
Bleeding Tendencies	YES ☐ NO ☐	Stomach Problems	YES ☐ NO ☐		

HEIGHT | WEIGHT

This information is correct and complete to the best of my knowledge, and I give my permission for you to contact and communicate with my physicians and insurance company.

Patient Signature_____Date_____

NAME | DATE

Thank You for Choosing FPSA

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GENERAL PATIENT HISTORY

Do you have (or have you had)any of the following?

PAST YES	PAST NO		PRESENT YES	PRESENT NO
☐	☐	Nasal Allergy	☐	☐
☐	☐	Post-Nasal Discharge	☐	☐
☐	☐	Sinus Infections	☐	☐
☐	☐	Nose Bleeds	☐	☐
☐	☐	Headaches	☐	☐
☐	☐	Hepatitis	☐	☐
☐	☐	Difficulty Breathing Through Nose	☐	☐
☐	☐	Sleep Apnea	☐	☐
☐	☐	Do You Use a CPAP	☐	☐
☐	☐	Heart Trouble	☐	☐
☐	☐	Mitral Valve Prolapse	☐	☐
☐	☐	Diabetes	☐	☐
☐	☐	Ulcers	☐	☐
☐	☐	Anemia	☐	☐
☐	☐	Asthma	☐	☐
☐	☐	Pulmonary Trouble	☐	☐
☐	☐	High Blood Pressure	☐	☐
☐	☐	+HIV/AIDS	☐	☐

Have you ever smoked? YES ☐ NO ☐

Do you currently use tobacco? YES ☐ NO ☐

How many packs a day?

How many years?

Do you drink alcohol? YES ☐ NO ☐

How many drinks per day?

Indicated if drugs or alcohol posed a dependency problem for you: DRUGS ☐ ALCOHOL ☐

Have you had exposure to HIV through prior sexual history, surgery, transfusions or IV drug use? YES ☐ NO ☐

Have you had a reaction to anesthetics? YES ☐ NO ☐

Do you have a history of increased bleeding tendency? YES ☐ NO ☐

Have you ever had a blood transfusion? YES ☐ NO ☐

Have you ever been under the care of a psychiatrist? YES ☐ NO ☐

Have you ever had a nervous breakdown? YES ☐ NO ☐

Do you wear glasses? YES ☐ NO ☐

Are your glasses just for reading? YES ☐ NO ☐

Do you wear contacts? YES ☐ NO ☐

Do you have a history of bad scarring? If yes, where? YES ☐ NO ☐

FACIAL PLASTIC SURGERY ASSOCIATES

HIPAA AUTHORIZATION FORM

Authorization for Release of Information

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.Parts 160 and 164)

1. **AUTHORIZATION:** I authorize **FPSA** to use and disclose the protected health information described below to

_____ (individual seeking the information).

☐ All ☐ Please specify what we cannot share, if not all: _____

2. **EFFECTIVE PERIOD:** This authorization for release of information covers the period of healthcare from:

a. _____ to _____ **OR** ☐ All past, present, and future periods.

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

PATIENT SIGNATURE	DATE
WITNESS	DATE

OR, IF YOU DO NOT AUTHORIZE FPSA DISCLOSE PROTECTIVED HEALTH INFOMATION TO ANYONE, SIGN BELOW.

PATIENT SIGNATURE	DATE
WITNESS	DATE

NAME	DATE

Thank You for Choosing FPSA

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FACIAL PLASTIC SURGERY ASSOCIATES

PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED.

1. Your confidential healthcare information may be released to other healthcare professionals within Facial Plastic Surgery Associates for the purpose of providing you with quality healthcare.

2. Your confidential healthcare information may be released to your insurance provider for the purpose of Facial Plastic Surgery Associates receiving payment for providing you with needed healthcare services.

3. Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.

4. Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.

5. Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event of a biological product (food or medication).

6. Your confidential healthcare information may not be released without your written authorization for any other purpose than that which is identified in section 1-5.

7. Your confidential healthcare information may be released for purposes other than those described in section 1-5 only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.

8. You may be contacted by Facial Plastic Surgery Associates to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

9. You may be contacted by Facial Plastic Surgery Associates for the purposes of raising funds to support the organization's operations.

10. You have the right to restrict the use of your confidential healthcare information. However, Facial Plastic Surgery Associates may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.

11. You have the right to receive confidential communication about your health status.

12. You have the right to review and photocopy any/all portions of your healthcare information.

13. You have the right to make changes to your healthcare information as long as the changes maintain the integrity of the medical record and/or continue to accurately describe the care provided.

14. You have the right to know who has accessed your confidential healthcare information and for what purpose.

15. You have the right to possess a copy of the Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.

16. Facial Plastic Surgery Associates is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.

17. Facial Plastic Surgery Associates will abide by the terms of this notice. The organization reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.

18. You have the right to complain to Facial Plastic Surgery Associates if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to:
ATTN: Practice Administrator, Facial Plastic Surgery Associates, 6655 Travis Street, #900, Houston, Texas 77030

ALL COMPLAINTS WILL BE INVESTIGATED. NO PERSONAL ISSUE WILL BE RAISED FOR FILING A COMPLAINT WITH THE ORGANIZATION.

- For further information about this Privacy Notice, please contact: Practice Administrator: (713) 526-5665
- This notice is effective as of Date of Effectiveness. This date must not be earlier than the date on which the notice is printed or published.

PATIENT SIGNATURE	DATE
WITNESS	DATE

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PATIENT STICKER

FACIAL PLASTIC SURGERY ASSOCIATES

NEW PATIENT QUESTIONNAIRE

Please help us help you by filling out the following information. It is our intention to make your consultation and surgical experience with us productive, enjoyable and goal directed. Your complete and specific information is essential to our communication and achieving the optimal results.

1. What is the primary reason that you are here?

2. What three aesthetic changes would you like to effect?

1.

2.

3.

3. What are your concerns or road blocks to having a procedure?

4. What are your short-term and long-term goals?

5. If you have had any experience with plastic surgery, please explain briefly.

6. What would you expect from this office, from the front office staff, the doctor and the medical team?

OVER ▶

7. Have you visited other doctors for consultation regarding any of the previous reasons?

8. What were their comments and/or recommendations?

9. What do you expect to achieve for yourself and your life with any aesthetic improvement?

10. Do you believe your expectations are realistic for improvement?

11. How likely is it that you would be satisfied with improvement and not "perfection"?

12. Do you have the time to invest to achieve the most optimal cosmetic improvements?

Thank you again for completing this information as completely and honestly as possible. This information will be valuable in allowing us to make your experience as positive and pleasant as possible.

NAME

DATE

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