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

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.

NAME | DATE

S:Administration\2011Forms\PtHistory

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 ☐

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HIPAA AUTHORIZATION FORM

Authorization for Release of Information

Section A:

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

PATIENT NAME	ID NUMBER

Persons/organizations providing the information:

Person/organizations receiving the information:

Specific description of information (including date(s)):

Section B:

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on (MM/DD/YYYY).

DATE	INITIALS

2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, it won't have any affect on any actions they took before they received the revocation.

INITIALS

Signature and Date of patient or patient's representative (Form MUST be completed before signing)

PRINTED NAME OF PATIENT'S REPRESENTATIVE:	RELATIONSHIP TO THE PATIENT:

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

By signing this document, I acknowledge that I have received a copy of Facial Plastic Surgery Associates Notice of Privacy Practices.

NAME (PRINT)	SIGNATURE	DATE

Facial Plastic Surgery Associates Office Use Only

NAME OF FPSA EMPLOYEE	DATE ACKNOWLEDGEMENT RECEIVED OR REASON ACKNOWLEDGEMENT WAS NOT OBTAINED:

NAME	DATE

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

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

PATIENT EMPLOYER	OCCUPATION

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

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

How did you hear about us?

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