J Gonzalez, MD Aesthetic Surgery
F. Jorge Gonzalez, MD

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

DOB: _____ Age: _____ Sex: _____ SSN: _____

Email Address: _____

Who is your primary care physician and mention your last visit? _____

Preferred Pharmacy (name and location): _____
How did you hear about our practice?

☐ Patient: _____ ☐ Friend: _____

☐ Other: _____

Emergency Contact

Name: _____ Relationship: _____
Phone Number: _____

Consent to Communicate: Please mark the ways that we can communicate with you.

Method	OK to leave Voicemail?	OK to Leave Message with Another Person?	Pick a Preferred Contact Method(s)	Best Time to Call
☐ Call Home Phone	☐ Yes	☐ Yes	☐	_____
☐ Call Cell Phone	☐ Yes	☐ Yes	☐	_____

☐ Send Text Message. Cell Phone Carrier: _____

☐ Text Appointment Reminders ☐ Text Medical/ Schedule Info

Patient's Signature: _____ Date: _____

Health History

Name: _____ D.O.B. _____

Section I: Surgery and Anesthesia History

Have you had any surgeries before? ☐ No ☐ Yes
If yes, Please List: _____

Have you had any serious injuries or accidents before? ☐ No ☐ Yes
If yes, Please List: _____

Do you or anyone in your family have had anesthesia complications before? ☐ No ☐ Yes
If yes, Please Describe: _____

Section II: Specific Medical History

Height: _____ Weight: _____ (Office Use Only) BMI: _____

Do you have a history of the following?	No / Yes		No / Yes
1. Anemia	☐ ☐	16. Bronchitis	☐ ☐
2. Asthma	☐ ☐	17. Migraine headaches	☐ ☐
3. Lung disease	☐ ☐	18. Periodontal disease	☐ ☐
4. Bleeding tendency	☐ ☐	19. Stroke	☐ ☐
5. Blood clots	☐ ☐	20. Thyroid disease	☐ ☐
6. Cancer	☐ ☐	21. Pneumonia	☐ ☐
7. Diabetes	☐ ☐	22. Tuberculosis	☐ ☐
8. High Blood Pressure	☐ ☐	23. Stomach Ulcer	☐ ☐
9. Heart disease	☐ ☐	24. Back Problems	☐ ☐
10. Hepatitis	☐ ☐	25. Leukemia	☐ ☐
11. Herpes/Cold Sores	☐ ☐	26. HIV Positive	☐ ☐
12. Kidney disease	☐ ☐	27. Have you been advised to or had psychiatric care?	☐ ☐
13. Epilepsy or seizures	☐ ☐		
14. Depression, Anxiety, Psychosis	☐ ☐	28. Heart Attack	☐ ☐
15. Have you had Blood Transfusion?	☐ ☐	29. Have you taken steroids?	☐ ☐

30. Others Not Listed _____

Section III: Social History

	No / Yes	If yes, How Much?
1. Do you smoke?	☐ ☐	_____
2. Do you drink?	☐ ☐	_____
3. Have you gained or lost weight in the past year?	☐ ☐	_____

Section IV: Family History

1. Is your mother living? ☐ No ☐ Yes
   If no, List age and cause of death: _____
2. Is your father living? ☐ No ☐ Yes
   If no, List age and cause of death: _____
3. Are your siblings healthy? ☐ No ☐ Yes
   If no, please explain: _____
4. Do you have a family history of Breast Cancer? ☐ No ☐ Yes If yes, Who? _____

Section V: Medications

1. Have you been sick in the last month? ☐ No ☐ Yes If yes, explain: _____

List any medications, and oral or topical vitamins, herbal or dietary supplements you are taking:

Name of Medication	Strength	How many times a day?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Section VI: Allergies and Sensitivities to medications

List all allergies and sensitivities: ☐ Check Here if you don't have any allergies.

Allergy:	**Severity:**	**Reaction:**
	☐ Mild ☐ Moderate ☐ Severe	
	☐ Mild ☐ Moderate ☐ Severe	
	☐ Mild ☐ Moderate ☐ Severe	

1. Are you allergic to medical adhesives such as tape, steri-trips, bandaids, latex or any other?
   ☐ No ☐ Yes If yes, please list: _____

Section VII: Women Only

1. Date of last mammogram: _____ 2. Number of Pregnancies: _____
3. Do you have regular breast self-exams? ☐ No ☐ Yes
4. Do you breast feed? ☐ No ☐ Yes
5. Breast lump or discharge? ☐ No ☐ Yes
6. Are you pregnant or trying to get pregnant? ☐ No ☐ Yes
7. Are you on birth control pills or hormone replacement therapy? ☐ No ☐ Yes

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

Questionnaire

To make sure we address your questions and meet your goals, we ask that you take a moment to answer the following questions. Your input will help Dr. Gonzalez together with our staff customize a surgical plan for you.

Questions about your visit:

1. What type of plastic procedure are you interested in?
   _____
2. How long have you wanted to have this procedure for?
   _____
3. Have you consulted a plastic surgeon for this procedure before?
   _____
4. Have you ever had any type of plastic surgery?
   _____
5. Why have you selected Dr. Gonzalez?
   _____

My goals for this consultation include discussing:

1. _____
2. _____

My Time for surgery is:

a. As soon as possible? if yes, when? _____
b. 1-3 months from now? if yes, when? _____
c. 6-12 months from now? if yes, when? _____
d. Only looking for information? _____

Health or personal factors that may affect my recovery:

1. _____
2. _____

I have determined a budget for my surgery and want to make sure we work within it:

☐ Yes ☐ No if yes, how much? _____

Other Comments: _____

Consent for Purposes of Treatment, Payment And Healthcare Operations (HIPAA)

I, _____, consent to the use or disclosure of my protected health information by **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez, MD)** for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez)**. I understand that diagnosis or treatment of me by **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez, MD)** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez, MD)** is not required to agree to the restrictions that I may request. However, if **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez MD)** agrees to a restriction that I request, the restriction is binding on **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez).**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez MD))** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a medical insurance provider, or my employer. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I authorize **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez MD)** to communicate with my physicians.

I understand I have a right to review **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez MD)'s** "Notice of Privacy Practices" prior to signing this document. The **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez MD)** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operation of the **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez MD)**. The Notice of Privacy Practices for **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez MD)** is provided at **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez MD).**. This Notice of Privacy Practices also describes my rights and **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez MD)'s** duties with respect to my protected health information.

J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez MD), reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy t be sent in the mail or asking for one at the time of my next appointment.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM. DO NOT SIGN THIS FORM IF YOU HAVE TAKEN MEDICATIONS WHICH MAY IMPAIR YOUR MENTAL ABILITIES OR IF YOU FEEL RUSHED OR UNDER PRESSURE.

_____ _____

Print Name Date

_____ _____

Patient Signature Witness

GONZALEZ MD
AESTHETIC SURGERY

Patient Photograph Release Form

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the members of **J Gonzalez MD Aesthetic Surgery** Staff. Any photographs taken will become part of my medical records. My photographs are to be used for the purposes of the office and medical chart. I hereby and authorize **J Gonzalez MD Aesthetic Surgery** and staff to take my photos and use them only for my surgery record with **Dr. Gonzalez**. I understand these photos will not be used on the office website or in any publications.

You have the right to revoke this consent in writing.

I authorize/allow **J Gonzalez MD Aesthetic Surgery** to take photos the day of my Consultation.

Patient's Name: _____

Patient's Signature: _____ Date: _____

GONZALEZ MD
AESTHETIC SURGERY

Authorization to Release Information

Many of our patients allow family members such as their spouse, parents or others to be present during their consultation. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have family members (spouse, parents or others) during your consultation with **Dr. Gonzalez**, you must sign this form. Signing this form will only give consent to release information to the family members indicated below. This consent form will not allow **J Gonzalez MD Aesthetic Surgery** to release any other information to these family members.

You have the right to revoke this consent in writing.

I authorize/allow **J Gonzalez MD Aesthetic Surgery** to release my information to the following individual(s):

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Patient Name: _____

Patient Signature: _____ Date: _____