Dr. Caroline J. Plamondon M.D.
Cosmetic & Reconstructive Plastic Surgery

Patient Information

Today's Date: _____

Welcome to our office. As a new patient, please fill out the information found below to the best of your ability. Please answer these health and beauty related questions to help us design the ideal experience for you. All information will remain confidential.

Patient Name / Responsible Party (if minor):_____

Mailing Address: _____

City:_____State/Country:_____ZIP:_____

Telephone: Home_____Work_____Cell_____

Date of Birth ___/___/_____Age_____Email Address:_____

SS#: _____ Preferred Method of Contact: ☐Home ☐Cell ☐Work ☐E-Mail

Sex: □Female □ Male **Marital Status:** □Single □Married □Widowed □Separated □Divorced

How did you hear about Caroline J. Plamondon, MD?
□Google □Facebook □RealSelf □Other/Define_____Referred by_____□patient

The information provided above and during your scheduling may be used to contact you. Please do not provide information if it cannot be used.

Please check all of Dr. Plamondon's surgical and non-surgical procedures that interest you.

FACE
- □ Facelift, Neck Lift
- □ Eyelid Surgery
- □ Nose Surgery (cosmetic and breathing)
- □ Facial Contouring, Fat Grafting
- □ Prominent Ear, Otoplasty
- □ Other_____

BREAST
- □ Breast Augmentation
- □ Breast Revision/Reconstruction
- □ Breast Lifts
- □ Breast Reduction
- □ Scar Revisions
- □ Nipple Surgery

BODY
- □ Tummy Tuck
- □ Liposuction
- □ Arm Lift (Brachioplasty)
- □ Other_____
- □ Other_____

NON-SURGICAL
- □ Botox Injections
- □ Dermal Fillers (e.g. Restylane, Juvederm)
- □ Microneedling with Radio Frequency
- □ Chemical Peels
- □ Anti-Aging, Prevention Skincare
- □ Sun Damage Repair
- □ Acne Treatments
- □ Scar Treatment
- □ PRP (Plasma Rich Protein) Therapy
- □ Other_____
- □ Other_____
- □ Not sure, need consultation

PRIMARY CARE PHYSICIAN / PEDIATRICIAN

Name: _____ Phone: _____ Address: _____

Pharmacy: _____ Phone: _____ Address: _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship: _____

INSURANCE

Plan Name: _____ Primary Insurer: _____ Subscriber ID: _____

Group#: _____ Secondary Insurance: _____

Assignment and Release (Insurance Patients Only)
I, the undersigned, have insurance coverage with the company named above. I assign, directly to Dr. Plamondon, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, including possible hospitalizations, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

Patient Signature:_____ Date: _____

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Patient Name:_____ Today's date:_____

Age:_____ Birthdate:_____ Date of last physical examination:_____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

General

- ☐ Chills
- ☐ Depression/Anxiety
- ☐ Eating Disorder *(Bulimia, Anorexia)*
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscle/Joint/Bone

Pain, weakness, numbness:

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

Gastrointestinal

- ☐ Poor appetite
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Reflux
- ☐ Stomach pain
- ☐ Ulcers
- ☐ Vomiting
- ☐ Vomiting blood

Genito-Urinary

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Eye, Ear, Nose, Throat

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

Women

Are you pregnant? ____

Number of children ____

Cardiovascular

- ☐ Chest pain/Heart attack
- ☐ Heart murmur or leaking valve
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood sugar
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

Skin

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

Conditions

Check (✓) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Blood clot
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Drug or Alcohol dependency
- ☐ Diabetes
- ☐ Emphysema
- ☐ Embolism
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis B or C
- ☐ Hernia
- ☐ High cholesterol
- ☐ HIV Positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraine headaches
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers

☐ Psychiatric Care

If yes, Doctor's Name

_____

Medications

List **all** medications you are currently taking.

_____

_____

_____

_____

Allergies

_____

_____

_____

_____

One Randall Square, Suite 408, Providence, Rhode Island 02904 Tel 401-272-6602 Fax 401-273-2900

Past Surgeries

Year	Hospital	Reason

Past Hospitalization for Serious Illnesses

Year	Hospital	Reason

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates: _____

Health Habits

Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Occupational

Check (✓) if your work exposes you to the following:

Stress ☐ Hazardous Substances ☐

Heavy Lifting ☐ Other ☐

Occupation

Family Health

Check ✓ If, your blood relatives had any of the following:

✓	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

Caroline J. Plamondon M.D.
Cosmetic & Reconstructive Plastic Surgery

INSURANCE WAIVER OF LIABILITY

Insurance regulations require that I inform you that your insurance company may possibly deny coverage for surgical procedures that have been requested by you or recommended to you by myself or other health care providers.

Most insurance companies' will either not pre-authorize surgery and/or may retroactively deny it. If this occurs, it is the policy of this office to bill you directly after appealing to your insurance company for you. It is recommended that you also appeal directly if your insurance company denies you coverage.
If your insurance company ultimately denies covering your surgery, you will be responsible for the surgical fee up to the reimbursement level normally provided by your insurance company.

Initial: _____

INSURANCE DEDUCTIBLE FOR SURGICAL PATIENTS

In the event you become a surgical patient, we require a copy of the front and back of your credit/debit card to cover any deductible that your insurance plan may indicate. Our office will verify this amount of ahead of time through your insurance carrier. We will submit the claim to your insurance carrier on your behalf.

If after the first billing cycle payment has not been received or arrangements have not been agreed upon, any outstanding deductible will be charged to the credit card you have provided us. A 2.5% convenience fee will be assessed to any charge over $100. You may also choose to write us a check which we will hold until we receive notification of payment from your insurance company. By signing below, I acknowledge that I have read and agree to the above policies.

Signature:_____

PRIVACY AND CONFIDENTIALITY NOTICE

We understand that many patients are concerned about the privacy surrounding their decision to have plastic surgery. This notice describes how the personal and medical information you provide may be used. Please review it carefully and sign below. If you have any questions, please do not hesitate to speak with our office staff.

Dr. Plamondon and her staff believe your personal and medical information should remain confidential. Your decision to enhance your look is a personal one and it is our pledge that we will safeguard the information you provide to the best of our abilities. Our efforts to safeguard your personal and medical information include training our staff on the principals and importance of patient confidentiality, keeping patient charts and photographs safe and secure, and transmitting only necessary information to facilities such as the hospital and anesthesiologist.

I have read and understand the Privacy and Confidentiality Notice and all questions have been answered to my satisfaction. I understand I may have a copy of the Privacy and Confidentiality Notice if I wish.

Initial: _____

CONSENT TO TAKE PHOTOGRAPS

I hereby authorize Caroline J. Plamondon, M.D. and her associates or licensees to take pre-operative and post- operative Photographs.

I understand that such photographs shall become the property of Dr. Plamondon and will be retained by Dr. Plamondon. I UNDERSTAND THAT TREATMENT WILL NOT BE GIVEN IF PRE-OPERATIVE AND POST-OPERATIVE PHOTOGRAPHS ARE NOT TAKEN AS THESE ARE A PART OF EVERY MEDICAL EXAMINATION AND A CRITICAL PART OF MY PATIENT CHART.

I also authorize Caroline J. Plamondon, M.D. to use these photographs for the purpose of teaching, as a tool to inform other patients, or as part of Dr. Plamondon's internet website. Photographs will always be used in an anonymous fashion. Body photographs never show the face; however, if the surgery involves part or the whole face, I still authorize Caroline J. Plamondon, M.D. to use the photographs as mentioned above. Please choose one of the following:

Restrictions: **Medical Chart only:** ☐
No face photos on the internet: ☐
All identifiable tattoos, piercings, etc; to be cropped out before internet use: ☐
NO Restrictions to use of photographs: ☐

I have read and understand the above policies.
Patient Signature: _____
Print Name: _____
Date:_____

CAROLINE J. PLAMONDON, M.D., M.Sc., F.R.C.S.C.
One Randall Square, Suite 408
PROVIDENCE, RI 02904
401-272-6602

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

THIS NOTICE TAKES EFFECT ON APRIL 14, 2003 AND REMAINS IN EFFECT UNTIL WE REPLACE IT.

1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address above.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluation the performance of employees, conduction training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

COURT ORDERS AND JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

PUBLIC HEALTH ACTIVITIES: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We
may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

WORKERS COMPENSATION: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

LAW ENFORCEMENT: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoena or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

APPOINTMENT REMINDERS: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

ALTERNATIVE AND ADDITIONAL MEDICAL SERVICES: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. Your Individual Rights

YOU HAVE A RIGHT TO:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information list at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you for each page, and postage if you want the copies mailed to you. Contact us using the information listed above for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

Questions and Complaints

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit or submit requests involving any of your rights in Section 4 of this notice by writing to the above address.

We will provide you with the address to file your complaint the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.