FACIAL PLASTIC SURGERY INSTITUTE

CONSULTATION AND MEDICAL HISTORY/DATA

Name_____Date of Birth_____Today's Date_____

Address:
Home_____
Street City State Zip Telephone

Marital Status: S, M, D, Sep., Widowed Spouse's name_____ Age(s) of Children_____

Your Occupation/Employer_____Spouse's Occupation/Employer_____

Home phone: _(_____)_____ May we contact you on your home phone? YES NO

Cell phone: _(_____)_____ May we contact you on your mobile phone? YES NO

Email: _____ May we send appointment reminders to your email? YES NO

Preferred Method of Contact (circle one): Home phone / Mobile phone / Email

How were you referred to us? _____

Emergency Contact: _____ Relationship_____ Phone #_____

If anyone, may we have your authorization to release your medical information if they should contact us?

Name_____Relationship_____

Name_____Relationship_____

Insurance Information (if applicable):

Insurance Carrier: _____ Policy Number:_____ Group Number:_____

Name of Policy Holder:_____ Policy Holder Date of Birth: _____

IN WHICH SURGICAL PROCEDURE(S) ARE YOU INTERESTED (Circle response)?

Rhinoplasty (nose)	Face or Necklift	Eyelid Lift	Lip Augmentation	Injectable Fillers	Botox	Laser Resurfacing
Skin Cancer Reconstruction	Protruding Ears	Earlobe deformity	Scar Revision	Hair Restoration	Removal of cysts/moles, etc	Liposuction
Chemical Peel	Dermabrasion	Other:				

If for cosmetic purposes, what specifically, do you wish to have corrected: (i.e. what don't you like about the above condition(s)?

_____

When did you begin to consider surgical correction?_____ Have you discussed this surgery with your family? Yes/No

Why have you decided to have it done at this point in time?_____

Have you consulted any other doctor about this? Yes/No When:_____

MEDICAL HISTORY (circle appropriate response)

No/ Yes Are you now taking any drugs or medications, including hormone replacement therapy, vitamins, nutritional supplements, green tea, herbs, etc? List names and dosages _____

No/ Yes Are you allergic to any prescription medications or allergic to latex, creams, tape, make-up, etc.? Also list your reaction (hives, swelling, nausea, etc): _____

When was your last physical examination?_____

List your Primary Care Physician: _____Address_____

City_____State_____Telephone_____

SURGICAL HISTORY

Please list any previous surgical procedures with approximate date performed (including skin surgery, teeth/gums, heart, abdomen, reproductive system, lasix or eye surgery): _____

Have you had previous cosmetic, plastic or reconstructive surgery? **Yes/No** When, and what was done?_____

_____

SURGICAL HISTORY (cont.)

If you have had previous cosmetic surgery, were you satisfied with the results?_____If not, why?_____

_____ Where was the surgery performed? _____

Were there complications? **Yes / No** Problems with Anesthesia? **Yes / No** Did you have a normal recovery? **Yes/ No**

Has anyone in your family or a close friend had cosmetic, plastic or reconstructive surgery?_____

What was done?_____By whom?_____

FAMILY HISTORY

Do you or any family members have: (indicate who)

Heart trouble_____Excessive bleeding tendencies_____Psychiatric or "nerve" problems_____
High blood pressure_____Diabetes_____Thyroid problems_____
Excessive bruisability_____Excessive scarring_____Delayed or poor healing_____

REVIEW OF SYSTEMS (circle response)

No Yes Migraines?
No Yes Hay fever, nasal allergies or asthma?
No Yes Vision changes or problems with your eyes? Explain_____
No Yes Chest Pain with exertion? Explain
No Yes Heart problems? Explain_____
No Yes Reflux or ulcers?
No Yes Sleep Apnea?
No Yes Liver, gall bladder trouble, "yellow jaundice", or hepatitis?
No Yes Kidney or bladder problems? Explain_____
No Yes Arthritis or autoimmune conditions (lupus, scleroderma, etc)?
No Yes Do you ever experience poor circulation in your fingers or toes?
No Yes Do you have frequent skin infections, irritations or rashes? Circle which one(s)
No Yes Frequent fever blisters or cold sores?
No Yes History of stroke or heart attack? Explain_____
No Yes Dizzy spells?
No Yes Has any part of your body ever been paralyzed or numb? Explain_____
No Yes Have you every been diagnosed with HIV/AIDS?
No Yes Anemia or blood disorders?
No Yes Thyroid disease?
No Yes Smoke or use nicotine in any fashion (patches, gum, etc)?
No Yes Drink more than two alcoholic drinks a day?
No Yes Have you ever received treatment for abuse of alcohol or drugs? Explain_____
No Yes Do you usually feel unhappy, depressed, or tired?
No Yes Have you ever had a "nervous breakdown"? Explain_____
No Yes Do you take medication for anxiety?
No Yes Have you ever considered consulting a psychiatrist, psychologist or counselor? Explain _____
No Yes Have you ever been under the care of a psychiatrist or psychologist? Explain_____

If you are a woman, are you still having periods? **Yes/No** Are you pregnant or trying to get pregnant? **Yes/No**
If you are a man, have you ever had prostate problems? **Yes/No**

If you have any other health problems that have not been covered, please explain: _____
_____

No Yes Do you accept the fact that every medical and surgical treatment is associated with risks and other imponderables?
No Yes Do you agree to comply with the pre and post treatment instructions while you are under their care?

Signed_____Date_____

HIPAA Information and Consent Form

The Health Insurance Portability and Arcountability 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

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 of 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 confldential 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 modiff 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 if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

Patient Name: _____

FPSI
FACIAL PLASTIC SURGERY INSTITUTE
DR. JORDAN RIHANI

Consent to Photograph or Film

I, _____, give consent that Dr Rihani- Facial Plastic Surgery Institute can photograph or film me but only to the extent necessary and so long as the images are used solely for purposes of (a) identifying me as a patient or for purposes of documenting my health status, diagnosis and treatment while a patient; (b) conducting education and training, quality assurance and performance improvement functions for and on behalf of Dr Rihani and its professional staff; and (c) publishing the results of my treatment on Dr Rihani's website which, in this particular case, required me to sign the HIPAA authorization form.

The purpose of this form is to obtain my prior written consent so that Dr Rihani may photograph or film me for one or more of the following purposes listed below for which I do hereby consent.

(Initial all purposes that apply):

_____ Use or disclosure of image for marketing or advertising purposes and patient education
_____ Use or disclosure of image for medical specialty board in formulating its examination of applicant physicians
_____ Use or disclosure of image in a professional presentation or journal publication

Unless earlier revoked, this authorization will expire on the end of the treating physician's practice of surgery, except there will be no expiration for the purpose of medical or scientific research or use in specialty board examinations.

I also agree to sign the HIPAA authorization form which permits Dr Rihani- Facial Plastic Surgery Institute, to use or disclosure these images but only to the extent permitted by HIPAA and other applicable laws and regulations.

Computer Imaging Disclaimer
Computer imaging may be used to better educate you about your upcoming surgery. Although an approximation of intended results is to be displayed, I realize that there are differences in graphic artistic ability and surgical technique. I realize that computer imaging does not constitute and should not be construed to be an exact representation of post-surgical results. I understand that it is impossible to guarantee intended results. I understand that the alteration of any images is purely for the purpose of education, illustration and discussion.

_____ _____
Patient (or Patient's Legal Representative) Signature Date

_____ _____
Witness Signature Date