FACIAL PLASTIC SURGERY INSTITUTE

NEW PATIENT PAPERWORK

Name _____ Date of Birth _____

Address: _____

Street City State Zip

Your Occupation/Employer_____ Marital Status: S, M, D, Sep., Widowed Spouse's name_____

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

Emergency Contact: _____ Relationship_____ Phone #_____

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

Name_____Relationship_____

How were you referred to us?

Circle all that apply: Facebook/Instagram/Magazine/Google Ad/Current Patient: _____

Insurance Information (if applicable): Ins. Carrier: _____ Policy #:_____ Group #_____

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

List your Primary Care Physician: _____ When was your last physical examination?_____

Telephone: _____Address_____

Pharmacy Information: Name:_____ Phone: _____ Address:

_____

MEDICAL HISTORY (circle appropriate response)

Height: _____ Weight:_____lbs

Please list **any drugs or medications** you are currently taking (Including hormone replacement therapy, vitamins, nutritional supplements, green tea, herbs, etc) List names and dosages:_____

_____

Please list **any allergies** to prescription medications/antibiotics/latex/creams/tape/make-up, etc.? Also list your reaction (hives, swelling, nausea, etc):_____

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

_____

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

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

_____

If you have had previous cosmetic surgery, were you satisfied with the results? _____

If not, why?_____

Where was the surgery performed? _____

FAMILY HISTORY

Do you or any family members have: (**Circle & please indicate who**)

Heart trouble_____ Excessive bleeding tendencies_____ Thyroid problems_____

Psychiatric or "nerve" problems_____ High blood pressure_____ Diabetes_____

Excessive bruisability_____ Excessive scarring_____ Delayed or poor healing_____

REVIEW OF SYSTEMS (circle response)

No Yes Have you ever had **fever blisters or cold sores**?
No Yes Migraines?
No Yes Hay fever, nasal allergies or asthma? (Circle all that apply)
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? (Circle which one(s) apply)
No Yes Kidney or bladder problems? Explain_____
No Yes Arthritis or autoimmune conditions (lupus, rhuematoid arthritis)? Explain_____
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 all that apply)
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 ever 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)? How many packs/day? _____**
No Yes Drink more than two alcoholic drinks a day? How many drinks/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 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: _____

_____

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	Removal of cysts/moles, etc	Chemical Peel	Liposuction
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 consulted any other doctor about this? **Yes/No** If yes, when: _____

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

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_____ **Today's Date**_____

HIPAA lnformation and Consent Form

The Health lnsurance Portability and Arcountability Act (HIPAA) provides safeguards to protect your privacy. lmplementation 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 lnformation (PHl). 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. lt 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 conflдential 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 PHl. 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 lnformation form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Patient Name: _____Signature: _____**Date: _____**

Consent to Photograph or Film

I, _____, give consent that Dr. Rihani – Facial Plastic Surgery Institute can photograph me but only to the extent necessary and so long as the images are used soley for purposes of (a) identifying me as a patient or for purposes of documenting my health 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.

Please inital below to provide consent:

_____ 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

_____ Use of images on Social Media

OR ☐ I do **NOT** consent (Photographs will still be taken for patient record during consultation)

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.

Signature:

_____ **Date**: _____