

■ Patient Information

Today's Date: \_\_\_\_\_

Title: Dr. Mr. Mrs. Ms. \_\_\_\_\_ Name (Last, First, Middle) \_\_\_\_\_

Gender:  M  F Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Social Security: \_\_\_\_\_

Street Address \_\_\_\_\_

City, State & ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email address \_\_\_\_\_

Check if Minor (less than 18) Marital Status:  Single  Married  Divorced  Widowed  Separated

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

■ Parent /Guardian Information

To be completed if the patient is a minor or if a guardian has power of attorney over the patient's medical care.

Title: Dr. Mr. Mrs. Ms. \_\_\_\_\_ Name (Last, First, Middle) \_\_\_\_\_

Email address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

■ How did you hear of us?

Friend: \_\_\_\_\_  Newspaper: \_\_\_\_\_

Our patient: \_\_\_\_\_  Our Website: \_\_\_\_\_

Magazine: \_\_\_\_\_  Television: \_\_\_\_\_

Physician referral: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

■ Authorization

I hereby authorize medical treatment of the person named above, and agree to pay all fees and charges for treatments and services rendered. I understand that medical treatment may include a review of personal, social and medical history, discussion of the reason(s) for the visit(s), and may include photographs of the area(s) being discussed and or treated before and/or after treatment. Should Plastic Surgery & Dermatology of NYC agree to submit my charges to my health plan, I agree to assign it all plan payments, and agree to promptly pay any remaining balance. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Please note that we require a copy of your government-issued photo identification for your record.**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

List the reason(s) for your visit today: \_\_\_\_\_

List all medical conditions for which you are presently being treated: \_\_\_\_\_

List all skin conditions you have previously been diagnosed with and/or treated for: \_\_\_\_\_

## ■ Personal Medical History

Please mark all past and present medical conditions:

### Cardiovascular:

- High blood pressure
- Heart attack(s)
- Pacemaker
- Coronary artery disease
- Murmur / Mitral valve prolapse
- Irregular heartbeat / palpitations
- Other: \_\_\_\_\_

### Pulmonary:

- Asthma
- Chronic lung disease
- Chronic cough
- Shortness of breath
- Other: \_\_\_\_\_

### Neuromuscular:

- Arthritis
- Muscle weakness
- Nerve damage
- Facial paralysis / Weakness
- Headaches
- Seizure disorder / Convulsions
- Spinal / Back disorders
- Other: \_\_\_\_\_

### Psychological:

- Depression
- Anxiety
- Claustrophobia
- Receive(d) psychiatric treatment
- Drug / Alcohol dependency treatment
- Psychiatric hospitalization
- Other: \_\_\_\_\_

### Ears / Nose / Throat:

- Nasal Difficulties
- Difficulty breathing by nose
- Previous nasal injury
- History of sinus infections
- Hearing difficulty
- Hoarseness
- Other: \_\_\_\_\_

### Eyes:

- Dry eye
- Blurred / Double vision
- Cornea problems
- Glaucoma
- Thyroid eye disease
- Wears glasses or contacts
- Other: \_\_\_\_\_

### Endocrine:

- Diabetes
- Thyroid disease
- Lupus
- Other: \_\_\_\_\_

### Hepatic:

- Hepatitis (Type: \_\_\_\_)
- Pancreatitis
- Cholecystitis
- Other: \_\_\_\_\_

### Renal:

- Renal failure
- Dialysis
- Other: \_\_\_\_\_

### Hematology:

- Blood transfusion
- Bleeding disorder
- Other: \_\_\_\_\_

### Gastrointestinal:

- Colitis
- Reflux disease
- Stomach ulcers
- Other: \_\_\_\_\_

### Allergic / Immunologic / Infectious:

- Hay fever
- HIV / AIDS
- Sexually transmitted disease
- Tuberculosis (TB)
- Autoimmune disorder
- Other: \_\_\_\_\_

### Dermatological:

- Excessive sweating
- Cold sores / herpes
- Acne
- Rosacea
- Eczema
- Psoriasis
- Radiation to face / neck
- Scarring / Keloid formation
- Other: \_\_\_\_\_

### Cancer:

- Basal cell cancer  
Location: \_\_\_\_\_
- Squamous cell cancer  
Location: \_\_\_\_\_
- Melanoma  
Location: \_\_\_\_\_
- Breast cancer
- Ovarian cancer
- Lung cancer
- Colon cancer
- Prostate cancer
- Other: \_\_\_\_\_

Please list any other conditions not listed above: \_\_\_\_\_

Do you faint easily? .....  Yes .....  No



Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

- Are you currently, or have you recently, taken any medications containing Aspirin?..... Yes .....  No  
Have you been on Accutane therapy within the past 24 months? ..... Yes .....  No  
Have you taken any steroid preparation(s) over the past year? ..... Yes .....  No

### ■ Allergies

If you have no allergies at all, check this box and skip to the next section.

If you do have allergies, please check all items that you have had an allergic reaction to:

- Penicillin     Sulfa     Lidocaine     Novocaine     Eggs     Latex

If you marked any of the above, please describe the reaction(s): \_\_\_\_\_

Please list all other drug and food allergies, including products such as tape , and the nature of your reaction:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### ■ Family Medical History

Please mark which of your relatives have or had the following conditions. List which blood relative are / were affected.

	Mother	Father	Blood Relative(s)
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Basal Cell Skin Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer (other than skin cancer) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eczema .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Melanoma .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psoriasis.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Squamous Cell Skin Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other skin condition.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

### ■ Social History

Do you smoke? ....  No .....  Yes (#/Day: \_\_\_\_\_) .....  I did, but I quit (Quitting date: \_\_\_\_\_)

Do you drink alcohol? .....  No .....  Yes      Do you use recreational drugs? .....  No .....  Yes

How often do you exercise? .....  Daily .....  1 x per week .....  2-3 x per week .....  4-6 x per week

Do you use sunscreen? .....  Daily .....  Always if sunny .....  Sometimes if sunny .....  Rarely / Never

What brand facial soap do you use? \_\_\_\_\_      What brand moisturizer do you use? \_\_\_\_\_

What brand body soap do you use? \_\_\_\_\_

Are you using birth control? .....  No .....  Yes ..... If Yes, method: \_\_\_\_\_

### ■ Review of Systems

Have you had any significant weight change in the past year? \_\_\_\_\_ lb loss      \_\_\_\_\_ lb gain       No

What is your height? \_\_\_\_\_      What is your current weight? \_\_\_\_\_

## ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing Plastic Surgery & Dermatology of NYC for your cosmetic, aesthetic and/or dermatologic needs. For your convenience, and to avoid any future misunderstandings, we would like to share the following policies with you so that you understand your responsibilities regarding our charges and fees.

1. We do not participate with any health insurance plans. You are responsible for all charges. Some charges are payable in advance, while others are payable upon exiting the office after the visit/procedure. In cases where charges are to be pre-paid, this will be explained prior to provision of those services. Our general policy is:
  - a. Plastic surgery procedures must be paid in full at least 2 weeks prior to the scheduled surgery date.
  - b. For laser treatments, most fillers (including Restylane, Radiesse, Juvederm, Perlane, Cosmoderm & Cosmoplast) and other cosmetic treatments (including Botox), a deposit must be paid when reserving the appointment. As of this time, the deposit is \$150, although this is subject to change. The balance is due upon exiting the office. If you should need to cancel your appointment, the balance will be reimbursed, provided your cancellation is made with at least two (2) business days notice. Cancellations after this time will forfeit the deposit.
  - c. To obtain a cosmetic appointment for Sculptra, a \$1,000 deposit is required. The balance is due upon exiting the office. If you should need to cancel your appointment, the balance will be reimbursed, provided your cancellation is made with at least three (3) business days notice. Because the product must be prepared in advance, and quickly expires, cancellations after this time will forfeit the deposit.
  - d. All appointments made with Plastic Surgery & Dermatology of NYC require a credit card on file. If you should need to cancel your initial appointment, no fee will be charged to your card, provided your cancellation is made with at least two (2) business days' notice. For follow-up appointments with the doctors, and all appointments with the Aesthetician, the cancellation deadline is one (1) business day's notice. Cancellations after the relevant times listed above, or failure to attend the appointment, will be charged a \$150 fee on your credit card.
  - e. For all non-prepaid services, charges are payable immediately after the procedure.
2. We accept Visa, MasterCard and American Express credit cards, as well as personal checks and cash.
  - a. We require a credit card security for personal checks.
  - b. There is a \$50.00 fee for returned checks, which will be added to your charges and then deducted from your credit card.
  - c. We reserve the right to send all accounts with balances older than 60 days to an outside collection agency. This will also result in a \$90.00 processing fee, as well as any additional fees assessed by the collection agency.
3. If you participate with a health insurance plan, and wish to file a claim with your carrier for reimbursement of dermatology fees, we will be happy to provide you with a detailed receipt. Please ask for it upon payment.
4. Plastic surgery charges are determined by the particular surgery being performed as well as the patient's medical conditions and the doctor's determination of the procedure's complexity. The fees for each surgery will be explained by our business manager after your consultation with the doctor. The fee for your initial consultation is nonrefundable – however, it will be deducted from your surgical procedure, if performed within 4 months of your consultation.
5. Dermatology charges for evaluation and maintenance visits are determined by the complexity of the medical decision making and time involved in your visit. Procedures and materials are charged in addition to the fees for the consultation. If you require an advance estimate of such fees, please ask for it before services are rendered.
6. If you participate with a health insurance plan that requires you to have your laboratory specimens sent to a particular laboratory, and this office has a relationship with that laboratory, we will happily send your specimens to that laboratory at your request, unless the doctor determines that another laboratory is preferred for medical reasons. However, regardless of which laboratory patient specimens are sent to for analysis, you are entirely responsible for all charges assessed by the laboratory, and shall handle financial matters directly with the laboratory.

**I have read and understand the above. I fully understand and accept my financial responsibility for the charges I or my dependants may incur at this office.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

# PRIVACY PRACTICES ACKNOWLEDGEMENT & CONSENT

- ◆ I have received the Notice of Privacy Practices and/or have been provided an opportunity to review it.
- ◆ I agree that I can be contacted regarding my appointments, prescription renewals, lab results, and all other Protected Health Information\* ("PHI"), at the following telephone numbers, in addition to any other numbers provided to you by me:

( \_\_\_ \_\_\_ ) \_\_\_ \_\_\_ - \_\_\_ \_\_\_      Home / Office / Cell / Other: \_\_\_\_\_

( \_\_\_ \_\_\_ ) \_\_\_ \_\_\_ - \_\_\_ \_\_\_      Home / Office / Cell / Other: \_\_\_\_\_

( \_\_\_ \_\_\_ ) \_\_\_ \_\_\_ - \_\_\_ \_\_\_      Home / Office / Cell / Other: \_\_\_\_\_

\*as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its regulations, as may be amended from time-to-time

**◆ I understand that it is your policy not to reveal PHI on voicemail systems and answering machines, aside from upcoming appointment information. If I would like to permit you to leave non-appointment PHI messages on the voicemail systems or answering machines at the numbers I have provided, I will initial here: \_\_\_\_\_**

- ◆ I understand that it is your policy not to reveal PHI to my spouse, unless I enter his/her name below. I understand that it is your policy, in compliance with the law, to reveal PHI with my other physicians.
- ◆ I understand that it is your policy to email information and confirmation messages to the email address(es) I provided you. I also understand that this method of communication is one-way only, and that I may not contact the practice via email, neither for medical nor administrative matters.
- ◆ I agree that my PHI may be shared with the following other people (please indicate relationship):

\_\_\_\_\_ ( \_\_\_ \_\_\_ ) \_\_\_ \_\_\_ - \_\_\_ \_\_\_

\_\_\_\_\_ ( \_\_\_ \_\_\_ ) \_\_\_ \_\_\_ - \_\_\_ \_\_\_

\_\_\_\_\_ ( \_\_\_ \_\_\_ ) \_\_\_ \_\_\_ - \_\_\_ \_\_\_

\_\_\_\_\_ ( \_\_\_ \_\_\_ ) \_\_\_ \_\_\_ - \_\_\_ \_\_\_

*[Please place a star next to the name of the person you choose as your primary emergency contact.]*

- ◆ I understand that it is your policy that, when you receive telephone calls to discuss my medical care or records, all callers, including myself, will have to supply information that uniquely identifies me, such as the last 4 digits of my social security number and/or my birth date, and that without such a match no PHI will be revealed.
- ◆ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Plastic Surgery & Dermatology of NYC.

Patient Name (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

# COSMETIC & AESTHETIC INTEREST QUESTIONNAIRE

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please mark all products, procedures and treatments which you are interested in.

## ■ Cosmetic Dermatology

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Botox Cosmetic                       | <input type="checkbox"/> Chemical peel              | <input type="checkbox"/> Laser port wine stain reduction |
| <input type="checkbox"/> Nonsurgical brow lift                | <input type="checkbox"/> Vein treatment             | <input type="checkbox"/> Laser scar reduction            |
| <input type="checkbox"/> Collagen (Cosmoderm<br>/ Cosmoplast) | <input type="checkbox"/> Tumescent liposuction      | <input type="checkbox"/> Laser Facial Peel               |
| <input type="checkbox"/> Restylane                            | <input type="checkbox"/> Laser hair reduction       | <input type="checkbox"/> Laser psoriasis treatment       |
| <input type="checkbox"/> Perlane                              | <input type="checkbox"/> Laser vein treatment       | <input type="checkbox"/> Laser stretch mark reduction    |
| <input type="checkbox"/> Sculptra                             | <input type="checkbox"/> Laser tattoo reduction     | <input type="checkbox"/> Ear piercing                    |
| <input type="checkbox"/> Radiesse                             | <input type="checkbox"/> Laser adult acne treatment | <input type="checkbox"/> Age spot reduction              |
| <input type="checkbox"/> Juvederm                             | <input type="checkbox"/> Laser acne scar reduction  | <input type="checkbox"/> Torn earlobe repair             |
| <input type="checkbox"/> Lip augmentation                     | <input type="checkbox"/> Laser skin resurfacing     | <input type="checkbox"/> Hair replacement/restoration    |
|   | <input type="checkbox"/> Laser skin tightening      | <input type="checkbox"/> Skin tag removal                |

## ■ Plastic Surgery

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Face lift             | <input type="checkbox"/> Ear reshaping                | <input type="checkbox"/> Male breast reduction      |
| <input type="checkbox"/> Neck lift             | <input type="checkbox"/> Breast augmentation          | <input type="checkbox"/> Inverted nipple correction |
| <input type="checkbox"/> Fat transfer/grafting | <input type="checkbox"/> Breast reduction             | <input type="checkbox"/> Tummy tuck                 |
| <input type="checkbox"/> Eyelid lift/surgery   | <input type="checkbox"/> Breast lift                  | <input type="checkbox"/> Arm lift                   |
| <input type="checkbox"/> Nose contouring       | <input type="checkbox"/> Breast augmentation removal  | <input type="checkbox"/> Thigh lift                 |
| <input type="checkbox"/> Chin augmentation     | <input type="checkbox"/> Breast augmentation revision | <input type="checkbox"/> Dermabrasion               |

## ■ Aesthetician Treatments

- |  |                                      |   |
|--|--------------------------------------|---|
| <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Masque      | <input type="checkbox"/> Eyebrow shaping    |
| <input type="checkbox"/> Facial            | <input type="checkbox"/> Hair waxing | <input type="checkbox"/> Eyelash Extensions |

## ■ Specialty Products

We are proud to offer our own line of PLASTIC SURGERY & DERMATOLOGY of NYC topical products, manufactured according to our strict standards.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Cleansing      | <input type="checkbox"/> Acne                   | <input type="checkbox"/> Post-Operative |
| <input type="checkbox"/> Toning         | <input type="checkbox"/> Melasma / Pigmentation | <input type="checkbox"/> Dandruff       |
| <input type="checkbox"/> Moisturizing   | <input type="checkbox"/> Anti-Aging             | <input type="checkbox"/> Ingrown Hairs  |
| <input type="checkbox"/> Sun Protection | <input type="checkbox"/> Rosacea                | <input type="checkbox"/> Eczema         |