South Shore Cosmetic Surgeons, LLC

**Patient Information as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (enter todays date)**

**(Please Print Legibly & Fill in All Fields)**

**Patients Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle

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

Street & Apt # City State Zip Code

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Age** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birthday** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SS #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sex:** ❑ Female ❑ Male

**Marital Status:** ❑ Single ❑ Married to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ **Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any restrictions for contacting you? ❑ Yes ❑ No Contact Restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Employer** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ext: \_\_\_\_\_\_\_\_\_\_\_\_ Is it okay to call you at work? ❑ Yes ❑ No

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

Street & Apt # City State Zip Code

**Emergency Contact** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(not in your household, if patients a minor, list parental information)

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH QUESTIONNAIRE**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician & Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason(s) for seeing Doctor today: 1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all medications you are taking: 1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**ALLERGIES**: **DESCRIBE REACTION**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Yes No**

Penicillin ❑⁯ ❑⁯ **Weight Loss:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Weight Gain:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Iodine ❑⁯ ❑⁯

Codeine ❑⁯ ❑⁯ Have you taken any aspirin in the last two weeks? ❑ Yes ❑ No

Other Meds ❑⁯ ❑⁯ **Smoke:** ❑ Yes ❑ No **If yes, how much?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Drink:** ❑ Yes ❑ No **If yes, how much?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all hospitalizations, operations (including plastic surgery) and serious injuries within the last 10 years:

**Year Hospitalization-Operation/Injury Hospital & Location**

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

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

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

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| **ILLNESS & MEDICAL PROBLEMS** HHHHosHosi  **Yes No Yes No Yes No**  Dizzy Spells ❑⁯ ❑⁯ Pneumonia ❑⁯ ❑⁯ Stomach Ulcer ❑⁯ ❑⁯  Glaucoma ❑⁯ ❑⁯ Tuberculosis ❑⁯ ❑⁯ Colitis ❑⁯ ❑⁯  Eye Problems ❑ ❑⁯ Lung Problems ❑⁯ ❑⁯ Diverticulosis ❑⁯ ❑⁯  Ear Trouble ❑⁯ ❑⁯ High Blood Pressure ❑⁯ ❑⁯ Bowl Problems ❑⁯ ❑⁯  Sinus Trouble ❑⁯ ❑⁯ Heart Attack ❑⁯ ❑⁯ Hepatitis \_\_\_\_\_\_ ❑⁯ ❑⁯  Diabetes ❑⁯ ❑⁯ Hearing Problems ❑⁯ ❑⁯ Mononucleosis ❑⁯ ❑⁯  Heart Murmur ❑⁯ ❑⁯ Heart Disease ❑⁯ ❑⁯ Gall Bladder Trouble ❑⁯ ❑⁯  Constant Nose Bleeds ❑⁯ ❑⁯ Bleeding Disorder ❑⁯ ❑⁯ Stroke ❑⁯ ❑⁯  Chronic Nose Blockage ❑⁯ ❑⁯ Anemia ❑⁯ ❑⁯ Convulsion/ Seizures ❑⁯ ❑⁯  Swelling in Neck ❑⁯ ❑⁯ Bleed Easily ❑⁯ ❑⁯ Scarlet Fever ❑⁯ ❑⁯  Asthma ❑⁯ ❑⁯ Bruise Easily ❑⁯ ❑⁯ Bronchitis ❑⁯ ❑⁯  Ankles Swell ❑⁯ ❑⁯ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ ❑⁯ ❑⁯ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑⁯ ❑⁯ |

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| **FAMILY HISTORY**  **Yes No Yes No**  Tuberculosis ❑⁯ ❑⁯ Diabetes ❑⁯ ❑⁯  Asthma ❑⁯ ❑⁯ Rheumatoid Arthritis ❑⁯ ❑⁯ Year Type of Cancer Relationship  Glaucoma ❑⁯ ❑⁯ Heart Disease ❑⁯ ❑⁯ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  High Blood Pressure ❑⁯ ❑⁯ Low Blood Pressure ❑⁯ ❑⁯ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Arthritis ❑⁯ ❑⁯ Bleeding Tendency ❑⁯ ❑⁯ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Trouble with Anesthesia ❑⁯ ❑⁯ Paralysis ❑⁯ ❑ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Blood Disorders ❑⁯ ❑⁯ Cancer ❑⁯ ❑ ⁯  (Sickle Cell Anemia, etc.) |

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| **WOMEN ONLY**  **Yes No Yes No**  Tender Breasts ❑⁯ ❑⁯ Fibrocystic Disease ❑⁯ ❑⁯ Age at 1st Pregnancy? \_\_\_\_\_\_\_\_\_  Discharge from Nipples ❑⁯ ❑⁯ Previous Mammogram ❑⁯ ❑⁯ Year \_\_\_\_\_\_\_\_\_\_\_\_\_  Lumps in Breast ❑⁯ ❑⁯ Change in Breast Size ❑⁯ ❑⁯  Menstrual Problems ❑ ❑ Did/do you breast feed ❑ ❑⁯ HHHHosHosi |

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

With my consent, **South Shore Cosmetic Surgeons, LLC** may use and disclose protected and healthcare information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I understand that this information serves as:

* A basis for planning my care and treatment,
* A means of communication among the many health professionals who contribute to my care,
* A source of information for applying my diagnosis and surgical information to my bill,
* A means by which a third-party payer can verify that services billed were actually provided, and
* A tool for routine healthcare operation such as assessing quality and reviewing the competence of healthcare professionals.

Please refer to the **South Shore Cosmetic Surgeons** Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent and my signature indicates I have reviewed it or I have declined to review it prior to signing.

**South Shore Cosmetic Surgeons** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **South Shore Cosmetic Surgeons**, 36 Lincoln Ave., Rockville Centre, NY 11570.

With my consent, **South Shore Cosmetic Surgeons** may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With my consent, **South Shore Cosmetic Surgeons** may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment cards, patient statements, or forms.

I have the right to request that **South Shore Cosmetic Surgeons** restrict how it uses or discloses my PHI to carry TPO. However, the practice is not required to agree to my requested restrictions, but if it does, in writing, it is bound by this agreement.

By signing this form, I am consenting to **South Shore Cosmetic Surgeons** use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **South Shore Cosmetic Surgeons** may decline to provide treatment to me.

If I were to sign a Photo Release Consent (which I’d receive at a later date), I will agree to allow **South Shore Cosmetic Surgeons** to use my pre and post treatment photographs within its practice to educate future patients as long as I am not identified by face or name. If I decide I do not want my photographs to be used, I will not sign a Photo Release Consent.

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Signature of Patient of Legal Guardian Print Name of Patient of Legal Guardian

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

Date