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:

	Yes	No
Penicillin	❑	❑
Iodine	❑	❑
Codeine	❑	❑
Other Meds	❑	❑
______________		

DESCRIBE REACTION: ____

Weight Loss: __________ **Weight Gain:** __________

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

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
________	____________________________	____________________________
________	____________________________	____________________________
________	____________________________	____________________________

ILLNESS & MEDICAL PROBLEMS

	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____________	❑	❑

FAMILY HISTORY

	Yes	No		Yes	No
Tuberculosis	❑	❑	Diabetes	❑	❑
Asthma	❑	❑	Rheumatoid Arthritis	❑	❑
Glaucoma	❑	❑	Heart Disease	❑	❑
High Blood Pressure	❑	❑	Low Blood Pressure	❑	❑
Arthritis	❑	❑	Bleeding Tendency	❑	❑
Trouble with Anesthesia	❑	❑	Paralysis	❑	❑
Blood Disorders (Sickle Cell Anemia, etc.)	❑	❑	Cancer	❑	❑

Year	Type of Cancer	Relationship
______	____________	__________
______	____________	__________
______	____________	__________
______	____________	__________

WOMEN ONLY

	Yes	No		Yes	No
Tender Breasts	❑	❑	Fibrocystic Disease	❑	❑
Discharge from Nipples	❑	❑	Previous Mammogram	❑	❑
Lumps in Breast	❑	❑	Change in Breast Size	❑	❑
Menstrual Problems	❑	❑	Did/do you breast feed	❑	❑

Age at 1st Pregnancy? ________

Year ____________

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.

____ ____

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

____

Date