PATIENT INFORMATION FORM

Today's Date: _____

Name: _____ **DOB:** _____ **Age:** _____

Home Phone: _____ **Work:** _____ **Cell:** _____

Address: _____ **Cell Carrier:** ☐ **AT&T** ☐ **Verizon** **Other:** _____

City: _____ **State:** _____ **Zip:** _____

Email: _____

Who can we thank for introducing you to our practice?

☐ Friend/Relative/Current Patient: _____

☐ Dr. Referral: _____

☐ Web Search Search Term:_____

☐ Practice Website ☐ Facebook

☐ Other: _____

Pharmacy Name and Phone Number:

Preferred Pharmacy: _____ City: _____ Phone: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Primary Insurance:

Insurance Name: _____ Policy #: _____ Card Copied by Staff: _____

Policy Holder: _____ Policy Holder Date of Birth: _____

Secondary Insurance

Insurance Name: _____ Policy #: _____ Card Copied by Staff: _____

Assignment and Release

I, _____, have insurance coverage and assign directly all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured / Guardian Date

Consent to Communicate

Method	Preferred	OK to leave Voicemail?	OK to speak with Another Person?
☐ Call Work Phone	☐	☐Yes ☐No	☐Yes ☐No
☐ Call Cell Phone	☐	☐Yes ☐No	☐Yes ☐No
☐ Call Home Phone	☐	☐Yes ☐No	☐Yes ☐No
☐ Email Appt Reminders	☐	☐ Email Medical Info	☐ Email Marketing Info
☐ Text Appt Reminders	☐	☐ Text Marketing Info	☐ Send Regular Mail

Is there anyone else we can discuss your medical treatment and test results with?

Name:	DOB:	Relationship:

_____ _____

Signature Date

Section I: Personal Medical History

Are you pregnant? ☐ No ☐ Yes Height: _____ Weight: _____

Are you currently under the care of a physician (other than annual exams)? ☐ No ☐ Yes

If YES, list what for: _____

Do you have any allergies to medications? ☐ No ☐ Yes Please list all & type of reaction: _____

_____

Please list all current medications (including over the counter): None ☐

_____

What herbal supplements do you use regularly? _____

Have you used Aspirin, NSAIDS (Motrin, Advil, Aleve), Coumadin or blood thinners in the last 10 days? ☐ No ☐ Yes

Have you ever used Accutane? ☐ No ☐ Yes If YES, when did you last use it? _____

Section II: Specific Medical History

Have **you** or do you still have:

	No	Yes		No	Yes
Asthma	☐	☐	Anesthesia Complications	☐	☐
Lung Disease (including COPD or Emphysema)	☐	☐	Blood Clotting/Bleeding Abnormalities	☐	☐
High Blood Pressure / Hypertension	☐	☐	Severe Allergies	☐	☐
Heart Disease	☐	☐	Repeated Infections	☐	☐
Liver Trouble including Hepatitis	☐	☐	Arthritis	☐	☐
Kidney Trouble	☐	☐	Cancer	☐	☐
Thyroid Imbalance	☐	☐	Problem Scarring (Keloids)	☐	☐
Diabetes	☐	☐	Migraines	☐	☐
Epilepsy or Seizures	☐	☐	Rosacea	☐	☐
Stroke	☐	☐	Frequent Cold Sores	☐	☐
Psychiatric Care (Please include Depression, OCD, Anxiety or Eating Disorders)				☐	☐
Others not listed: _____				☐	☐

Section III: Social History

Do you currently smoke? ☐ No ☐ Yes, how much? _____ Former smoker? ☐ No ☐ Yes, Quit date: _____

Do you drink alcohol? ☐ No ☐ Yes, how much, how often? _____

Do you exercise regularly? ☐ No ☐ Yes, how much, how often? _____

Do you have any children? ☐ No ☐ Yes, how many? _____

Section IV: Family Medical History

Any of your close family members (mother, father, sibling, grandparents, or children) have any of the following? None ☐

Bleeding Disorders: ☐ No ☐ Yes, who _____

Clotting Disorders: ☐ No ☐ Yes, who _____

Anesthesia Complications: ☐ No ☐ Yes, who _____

Cancer: ☐ No ☐ Yes, who _____

Problems Scarring (Keloids): ☐ No ☐ Yes, who _____

Section IV: Specific to Botulinum Toxins, Fillers, Chemical Peels, Prescription Products & Other Spa Services

Do you have any of the following specific allergies? None ☐

Lidocaine/Novocain? ☐ No ☐ Yes, list reaction _____

Hydroquinone or skin bleaching agents? ☐ No ☐ Yes, list reaction _____

Hypersensitivity to Latisse?: ☐ No ☐ Yes, list reaction _____

Any Botulinum toxin product? ☐ No ☐ Yes, list reaction _____

Gram-positive bacterial proteins? ☐ No ☐ Yes, list reaction _____

PLLA (dissolvable sutures), Carboxymethacellulose, Mannitol? ☐ No ☐ Yes, list reaction_____

Sodium Metabisulfite or Sulfites (found in foods & RX preservatives? ☐ No ☐ Yes, list reaction_____

Do you have a history of Erythema Abigne? ☐ No ☐ Yes

I certify that I have read this questionnaire and disclosed my medical history to the best of my knowlege:

_____ _____

Signature: Date:

HIPAA Information and Consent

Patient Name: _____

The Health Insurance Portability and Accountability 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 and available in our lobby.

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 or 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 confidential 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 modify 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: _____

PHOTO-VIDEO CONSENT

BEACHWOOD PLASTIC SURGERY
& MEDICAL SPA
3618 Park East Drive
Beachwood, OH 44122
216-514-8899

WESTLAKE PLASTIC SURGERY
& MEDICAL SPA
226 Crocker Park Dr., Suite 380
Westlake, OH 44145
440-871-8899

Before & After photographs are important proofs as to the success of your treatments. We fully realize the sensitive nature of these images and keep your identity protected at all times. Please read and authorize approved disclosures below.

I, _____, hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery &/or treatments. The photographs will be taken by one of the members of Dr. Goldman's medical staff. I hereby give consent that Beachwood • Westlake Plastic Surgery & Medical Spa 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 diagnosis and treatment and documenting my health status; (b) conducting education and training, quality assurance and performance improvement functions for and on behalf of Dr. Goldman and his professional staff.

Additionally, I give written consent for use of my photographs or film for one or more of the following purposes listed. My consent is subject only to the condition that I am not identified by name.

☐ No ☐ Yes: Initials _____ Use of image(s) on practice website(s), and/or social media accounts.

☐ No ☐ Yes: Initials _____ Use of image(s) for print or digital marketing & advertising purposes.

☐ No ☐ Yes: Initials _____ Use of image(s) in a professional presentation or journal publication.

☐ No ☐ Yes: Initials _____ If I agree to film a short video interview after my procedure for the purpose of explaining my experience to others, such video may be posted to practice website(s), practice social media accounts (such as, but not limited to: Facebook, Youtube, Instagram etc) **without** my name, unless I myself state my name.

By signing this form, I acknowledge my consent as listed above, and I further recognize that this consent form will supersede any other photo consent forms with a date prior to the date this form is signed. This consent may be revoked at any time by written request or by completion of a new form.

Signed:_____ Date:_____

Print Name: _____