Today's Date:
Patient Name:

PATIENT INFORMATION

Please Print

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Gender: Male Female Marital Status: M S W D SSN#: ___-___-____

Phone (H): _____ Phone (W): _____ ext. _____ Phone (C): _____

Preferred method of contact: _____

Address: _____ City/State: _____ Zip: _____

Occupation: _____ Employer: _____

Spouse or Contact Person: _____ Contact Phone: _____

Driver's License Number (if a minor, please use guarantor). Issuing State: _____ Number: _____

Email: _____ May we email you special offers? (please circle): Y N

Referred by: (please circle and/or specify in the space provided).

Realself.com_____ Friend/Relative:_____

Physician:_____ Magazine:_____

Google (what did you search for?):_____ Other:_____

Reason for today's visit: _____

AUTHORIZATIONS

I authorize medical treatment of the person named above and agree to pay all fees and charges for such treatment. I authorize Aesthetic Facial Surgery Center of New York to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Aesthetic Facial Surgery Center of New York determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and if applicable to process the insurance claim for services rendered at Aesthetic Facial Surgery Center of New York.

I understand that I am responsible for any balance due for professional services in excess of the benefits provided by my policy. I agree to pay for services not covered by my insurance policy. I understand I am responsible for obtaining any prior authorizations required by my insurance policy. I understand that in the event of collection action, I am responsible for any legal fees incurred.

Signature: _____ Date: _____

Today's Date:
Patient Name:
Patient Address:

ACKNOWLEDGEMENT AND CONSENT

I understand that Aesthetic Facial Surgery Center of New York (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I <u>have received</u> a copy of the Notice of Privacy Practices.

By:_____ Date:_____
(Patient)

-OR-

By:_____ Date:_____
(Patient Representative)

Description of Representative's Authority_____

Today's Date:
Patient Name:

MEDICAL HISTORY

Last Name: _____ First Name: _____ Middle Initial: _____

ALLERGIES: _____

CURRENT MEDICATIONS: _____

PAST SURGICAL HISTORY: _____

PAST MEDICAL HISTORY: Have you ever had any of the following? Please circle all that apply.

Anemia
Ankle Swelling
Bleeding Tendency
Cancer
Chest Pain
Coughing Blood
Depression
Diabetes
Dizziness
Emphysema
Endocrine Problem
such as thyroid
Heart Disease
Heart Attack
Hearing Problems
High Blood Pressure
HIV (AIDs)
Pneumonia
Shortness of Breath
Stroke
Thrombophlebitis
Ulcer
Vision Problems

HISTORY OF TOBACCO (Please circle)

Have you ever smoked? YES NO Are you currently smoking? YES NO

HISTORY OF ALCOHOL (Please circle)

Do you drink alcohol? YES NO Recovering Alcoholic? YES NO

HISTORY OF RECREATIONAL DRUGS (Please circle)

Have you ever used illicit drugs? YES NO

Do you currently use illicit drugs? YES NO Drug(s) of choice:_____

RELEVANT COSMETIC & HEALTH HISTORY

Have you had (Restylane, Collagen, etc.) injections? _____ Last injection? _____

Have you had Botox injections? _____ Last injection? _____

Are you currently pregnant? YES NO Are you currently breastfeeding? YES NO

Have you used Accutane? _____ For how long? _____

Have you had a bad reaction to local or general anesthesia? YES NO If yes, explain _____

Have you had significant emotional problems? YES NO If yes, explain _____

Have you had psychiatric care? YES NO If yes, explain _____

Have you seen other Plastic Surgeons about this same problem? YES NO If yes, explain _____

I hereby consent to be examined and treated by Oleh Slupchynskyj, MD and that the above information is correct.

_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE