Foglietti Fostyk Plastic Surgery

** Please fill out all sections completely**

Patient Name: _____ Sex: ___ Marital Status ____

Address: _____
Street city state zip code

Home ph: (_____) _____ Date of birth: _____ Age:_____

Work ph: (_____) _____ Mobile ph: (_____)_____

Employer/School: _____ Occupation: _____

Social Security #:_____ E-mail: _____
May we communicate via e-mail? [] Yes [] No
May we leave a message at home with other residents? [] Yes [] No
May we leave a message on your answering machine or voicemail? [] Yes [] No

Primary Care Physician: _____
Phone: (_____)_____
May we provide him/her with updated information? [] Yes [] No
Whom may we talk to about your medical concerns: _____
Relationship:_____ Phone: (_____)_____
Is this contact for emergency purposes only? [] Yes [] No_____

Primary Insured's Name: _____
Address (If different from patients):_____
Employer: _____
Work phone (_____) _____ Relationship to patient: _____
Social security #:_____ Date of birth: _____ Sex:____

Primary Insurance: _____ Name on Contract: _____
Secondary Insurance: _____ Name on Contract: _____

Minors: Child lives with: [] Both Parents [] Mother [] Father
Guardian: _____
Address: _____
Street City State Zip code
Home ph:(_____)_____ Work ph:(_____)_____
Mobile ph:(_____)_____

AUTHORIZATION: I hereby authorize Cosmetic Surgery Institute to administer treatment and perform procedures as necessary or advisable in the diagnosis and treatment of this illness/injury. In addition I hereby authorize and assign Cosmetic Surgery Institute to furnish information to insurance carriers concerning the illness/injury, including if necessary, photographs, and I hereby authorize and assign Cosmetic Surgery Institute all the payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as avid as the original.

Signature: _____ Date:_____

Patient Name:_____ Date:_____
Height:_____ Weight:_____ Age:_____ Sex_____ Race_____

Reason(s) for your visit: _____

How did you hear about us? **Facebook** ____ **Twitter**_____ **Instagram** ____ **Google**_____
Physician (name)_____ **Friend (name)**_____

Drug Allergies: Sulfa___ Codeine____ Penicillin____ Erythromycin____ **Other:**_____
NONE:_____ Reaction(s)_____
Food Allergies: shellfish____ peanuts____ eggs_____ **Other:**_____
NONE:_____
Latex Allergy: yes____ no____ Sensitive to adhesives: yes____ no_____

Current Medications: ****List additional on back page****

1)_____ Dose:_____ Purpose:_____
2)_____ Dose:_____ Purpose:_____
3)_____ Dose:_____ Purpose:_____

Do you take: Aspirin yes____ no____ *daily____ **as needed_____
Ibuprofen yes___ no____
Aleve yes___ no____ Vitamins:_____
Vitamin E yes___ no____ Supplements:_____
Other:_____ Herbals:_____
Oral Contraceptives: yes____ no____ Homeopathic Remedies:_____

Surgeries: 1)_____ Date:_____
2)_____ Date:_____
3)_____ Date:_____
4)_____ Date:_____
5)_____ Date:_____

Anesthesia Problems: yes___ no___ If yes, specify:_____

Previous **Cosmetic** Surgery (specify):_____ Year:_____

Medical Conditions:

____anemia
____asthma
____bleeding disorders
____blood clot (leg or lung)
____blood pressure (high)
____breathing problems
____cancer ( )
____chronic infections
____circulation
____cold sores/herpes
____congestive heart failure
____depression
____diabetes
____eating disorder
____emphysema
____fainting
____heart attack
____hepatitis (A)(B)(C)
____HIV
____hormonal changes
____joint replacements
____kidney disease
____liver disease
____migraines
____mitralvalve prolapse
antibiotic: yes__no__
____seizures
____sickle cell
____stroke
____thyroid
____other
Explain:_____
_____

****SEE BACK PAGE****

Additional Medications

4)_____ Dose:_____ Purpose:_____
5)_____ Dose:_____ Purpose:_____
6)_____ Dose:_____ Purpose:_____
7)_____ Dose:_____ Purpose:_____
8)_____ Dose:_____ Purpose:_____

Do you smoke? yes____ no___ If so, how much?_____How long?_____

Do you use alcohol? yes___ no___
Occasional_____ Never_____ History of Alcoholism_____

BREAST ***Early detection is the key***

History of breast disease in the family? yes___ no___ Family member?_____
Mammogram: yes___ no___ Last mammogram?_____
Breast biopsy: yes___ no___ Which breast?_____ Last breast exam:_____
Last menstrual period:_____ Hysterectomy? yes___ no___
Menopause:_____ *what year or age
Pregnancies:_____ No. of live births:_____ Caesarean(s)_____

Breast Implants/Augmentation: Do you have implants in currently? yes___ no___
Company:_____ Current implant size?_____ Style_____
Silicone:_____ Saline:_____ Desire to replace implants? yes___ no___
Do you desire breast implants? yes___ no___
Current bra size_____ Desired bra size_____

LEGAL CASES
Attorney:_____ Date of accident/injury:_____
Accident:_____ Nature of injury:_____
Place of treatment_____ Treating Physician:_____

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Privacy Consent

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent for care: I, with my signature, authorize this practice, and any employee working under the direction of the physician, to provide medical care for me, or to this patient in which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for release of information: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice.

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information for my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Consent related to the privacy notice: I have had the chance to review the practice privacy notice as part of this registration process. I understand that the terms of the privacy notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time.

Patient/Guardian_____ **Date:** _____

Name printed: _____ **If not patient, relationship:** _____

Copy of Practice Privacy statement signed or initiated with patient/guardian on: _____

Patient unable to sign privacy due to: _____