★ PLEASE fill out all sections of this form completely!

Patient Name: ______________________________ Date of Birth: ____/_____/________ Age:_______

Social Security #: _______- _____ - _________
(Necessary to locate current medical records)

Sex: ○ Female ○ Male ○ Nonbinary ○ Other

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

Mobile Phone: (____) ______________________ E-mail: ______________________________

Address: ________________________________________________________________
Street City State Zip Code

Home Phone: (____) ______________________ Work Phone: (____) ______________________

Employer/ School: ______________________________ Occupation: __________________________

Please ✓check authorizing consent to contact you and circle the preferred method of communication.

☐ Mobile phone: calls / voicemail/ text ☐ Home phone: calls / voicemail ☐ Email

May we leave a message with other residents at your home? ☐ YES ☐ NO

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Primary Care Physician: ______________________________ Phone: (____) ______________________

May we request or provide him/her with updated information about your care? ☐ YES ☐ NO

To whom may we discuss your medical treatment and/or concerns: ______________________________

Your relationship to them: ______________________________ Phone: (____) ______________________

Is this Contact for emergency purposes only? ☐ YES ☐ NO ______________________________

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Who is Legally responsible for payment on this account? ☐ Self ☐ Spouse Parent: ☐ Mother ☐ Father

Primary Insured 's Name:______________________________ Relationship to patient:__________________

Date of Birth: ____/_____/__________ Social Security # (last 4 digits) ___________ Phone: (____) ________________

Address: (if different from patient's)__________________________________________________

Employer:______________________________ Work Phone: (____) ______________________

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Primary Insurance Carrier: ______________________________ Name on Contract: ______________________

Secondary Insurance Carrier: ______________________________ Name on Contract: ______________________

Minors: (patients 18 yrs. or younger) Lives primarily with: ☐ Both Parents ☐ Mother ☐ Father ☐ Guardian

Guardian's Name: ______________________________ Mobile Phone: (____) ______________________

Home Phone: (____) ______________________ Work Phone: (____) ______________________

Address: ________________________________________________________________
Street City State Zip Code

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AUTHORIZATION: I hereby authorize Foglietti Fostyk Plastic Surgery 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 Foglietti Fostyk Plastic Surgery to furnish information to insurance carriers concerning the illness/ injury, including if necessary, photographs, and i hereby authorize and assign Foglietti Fostyk Plastic Surgery all the payments for medical and 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 valid as the original .

Signature:______________________________________ Date: ______________________

Patient Name: ______________________________ Date: ______________

Height: ____________ Weight: __________ Age:_______ Sex: ○ Female ○ Male ○ Nonbinary ○ Other

Race/Ethnicity that best describes you: ________________________

Reason(s) for your visit: ______________________________________________

How did you hear about us? ○ Google ○ Facebook ○ Instagram

○ Physician Referral (name) ____________________ ○ Friend (name) ______________________

Drug Allergies: ○ None ○ Sulfa ○ Codeine ○ Penicillin ○ Erythromycin

○ Other: ____________________ * Reaction(s): ______________________________

Food Allergies: ○ None ○ Shellfish ○ Peanuts ○ Eggs ○ Other:______________________

Latex Allergy? ○ Yes ○ No Sensitive to Adhesives? ○ Yes ○ No

CURRENT MEDICATIONS (Include all to avoid harmful drug interactions)

1.________________________ Dose:__________ Purpose:______________________

2.________________________ Dose:__________ Purpose:______________________

3.________________________ Dose:__________ Purpose:______________________

4.________________________ Dose:__________ Purpose:______________________

5.________________________ Dose:__________ Purpose:______________________

*Additional space below

Do you take: Aspirin ○ Yes ○ No Ibuprofen ○ Yes ○ No Aleve ○ Yes ○ No Vitamin E ○ Yes ○ No

Vitamins:______________ Supplements: ________________ Homeopathic ________________

Medical Marijuana: ____________ Other: ______________

Oral Contraceptives: ○ Yes ○ No Antibiotics: ○ Yes ○ No If yes, specify ____________________

Do you Smoke? ○ Yes ○ No If yes, how much ______________ For how long? _____________

Do you Vape? ○ Yes ○ No If yes, how much ______________ For how long? _____________

Do you drink Alcohol? ○ Yes ○ No If yes how often? ○ Daily ○ Weekly ○ Monthly ○ A few times/year

## Previous Surgeries:

1.______________________________ Date:______________

2.______________________________ Date:______________

3.______________________________ Date:______________

4.______________________________ Date:______________

5.______________________________ Date:______________

Previous Cosmetic Surgery (specify): ________________________________ Year:________

________________________________ Year:________

Anesthesia Problems? ○ Yes ○ No If yes, specify:____________________________

**SEE BACK PAGE**

MEDICAL CONDITIONS: (check all that apply)

- ☐ Alcoholism
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Blood Clot (leg or lung)
- ☐ Blood Pressure (High)
- ☐ Breathing Problems
- ☐ Circulation
- ☐ Cold sores/herpes
- ☐ Congestive heart failure
- ☐ Depression
- ☐ Diabetes- If yes, most recent A1c level ____________
- ☐ Eating disorders
- ☐ Emphysema
- ☐ Fainting
- ☐ Heart attack
- ☐ Hepatitis ○ A ○ B ○ C
- ☐ Hormonal Changes
- ☐ Joint Replacement
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ POTS
- ☐ Seizures
- ☐ Sickle Cell
- ☐ Stroke
- ☐ Thyroid
- ☐ Other

Explain:________________________
________________________

BREAST HEALTH HISTORY **Early Detection is the Key!**

History of breast disease in the family? ○Yes ○No If yes, which family member(s):________________________

Mammogram: ○ Yes ○ No Date of last Mammogram?__________________

Breast Biopsy: ○ Yes ○ No If yes, which breast ○ Left ○ Right Date of last breast exam: _____________

Last menstrual period: _________ Hysterectomy? ○ Yes ○ No Menopause? ○ Yes ○ No What age?______

Number of pregnancies: _______ Number of live births: _______ Caesarean(s) ○ Yes ○ No If yes, #______

Breast Implants/Augmentation: Do you currently have implants? ○ Yes ○ No

Name of manufacturer:_____________________ Current implant size: _____________ Style: ___________

○ Silicone ○ Saline Do you want to replace your current implants? ○ Yes ○ No

If you are here to discuss breast implantation,
What is your current bra size? __________ What is your desired bra size? __________

**Additional Medications***

6.______________________________ Dose:____________ Purpose:___________________________

7.______________________________ Dose:____________ Purpose:___________________________

8.______________________________ Dose:____________ Purpose:___________________________

★ Patients being seen for Legal Cases ★

Attorney's name:______________________________ Date of Accident/ Injury: _______________

Type of accident: ______________________________ Nature of injury ________________________________

Place of initial treatment________________________ Treating Physician's name________________________

**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 physicians, to provide medical care for me or to this patient of whom 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 not limited to) preventative, 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 copayments, 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 my 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 not agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse my 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 Signature**_________________________________________ **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:** _____________________________________________________

______________________________________________________________________________________