Patient Information Form – Appointment Date:_____

Patient Name: _____ Preferred Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Marital Status: Single ☐ Separated ☐ Married ☐ Widowed ☐ Divorced ☐

DOB & Age: _____ Race: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Gender: _____ SSN: _____ Email Address: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

Pharmacy Name:_____ Pharmacy Phone Number:_____
Pharmacy Address: _____

How did you hear about Davis Facial Plastic Surgery?

☐ Magazine Advertisement
☐ Social Media (Facebook, Instagram)
☐ Google
☐ Other: _____
☐ Patient Referral: _____
☐ Friend: _____
☐ Dr. Referral: _____

What is the reason for your visit? _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

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

Assignment and Release

I understand that all surgical fees are due PRIOR to surgery or at the time skin care and injectable services are rendered. Care Credit options are available for surgical fees only. Payments may be made by cash, check or credit card. A deposit is required in order to schedule a surgery date, which is 25% of the physician's fee. All remaining balances will be due in full at the pre-operative appointment which is typically two weeks before surgery. If you must delay or cancel your surgery, two weeks' notice must be allowed. If surgery is cancelled within the two week period, my deposit will be refunded and an administrative fee of $250 will be deducted.

_____ _____

Patient Signature Date

I authorize discussion and release of my general medical condition and diagnosis (including treatment, payment and health care operations), and/or in case of emergency contact:

1.Name:_____Relationship _____

Date of Birth:_____ Phone _____

2.Name _____ Relationship _____

Date of Birth: _____Phone _____

Release of Confidential Information

I authorize Davis Facial Plastic Surgery to release any and all medical information to physicians or medical facilities regarding my care. The information to be released may include office notes, laboratory tests, radiology studies and other testing and information. I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health care provider; the released information may no longer be protected by federal privacy regulations. I understand that this consent shall be valid for a period of 1 year from the date of authorization and may be revoked at any time upon written notice, except to the extent that the information had already been released in reliance upon this authorization. I further understand that the confidentiality of this information may be protected by Federal Regulations (42CFR, Part II) prohibiting any further disclosure of this information without specific written authorization of the Undersigned, or as otherwise regulated.

Patient Signature: _____

Section I: Allergies

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

_____

Section II: Medications

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list:

_____

_____

Section III: Vitals & Specific Medical History

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

	Have you or do you still have:	No	Yes	Description
2.	Asthma	☐	☐	
3.	Emphysema	☐	☐	
4.	High Blood Pressure	☐	☐	
5.	Heart Trouble	☐	☐	
6.	Hepatitis or Liver Trouble	☐	☐	
7.	Kidney Trouble	☐	☐	
8.	Diabetes	☐	☐	
9.	Epilepsy or Seizures	☐	☐	
10.	Stroke	☐	☐	
11.	Easy bruising or bleeding	☐	☐	
12.	Problem healing after surgery	☐	☐	
13.	HIV/AIDS	☐	☐	
14.	Others Not Listed:			

Section IV: Family History

	Have any blood relatives had any of the following?	No	Yes	Relationship
1.	Cancer	☐	☐	
2.	Bleeding Tendency	☐	☐	
4.	Heart Disease	☐	☐	
5.	High Blood Pressure	☐	☐	
6.	Repeated Infections	☐	☐	
7.	Chronic Lung Disease	☐	☐	
8.	Tuberculosis	☐	☐	
9.	Asthma	☐	☐	
10.	Severe Allergies	☐	☐	
11.	Kidney Disease	☐	☐	
12.	Arthritis	☐	☐	
13.	Mental Illness	☐	☐	
14.	Convulsions or Fits	☐	☐	
15.	Migraine Headaches	☐	☐	
16.	Diabetes	☐	☐	
18.	Thyroid Trouble	☐	☐	

Section V: Surgical History & Hospitalizations

1. Have you ever had surgery? ☐ No ☐ Yes, please list surgery and dates performed:

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

3. Have you ever been hospitalized? ☐No ☐Yes, please list dates and reason for hospitalization.

Section VI: Social History

1. Do you smoke? ☐ No ☐ Yes, how much?
2. Did you ever smoke? ☐ No ☐ Yes
3. Do you drink alcohol? ☐ No ☐ Yes, how much?
4. Do you use recreational drugs? ☐No ☐ Yes, describe?
5. Do you have children? ☐ No ☐ Yes, how many?

I have read this questionnaire and disclosed my medical history to the best of my knowledege.

Patient Signature: _____ Date: _____

Consent to Communicate

Patient Name: _____

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appointment Reminders				
☐ Email Medical Information				
☐ Email Office Specials				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Message – if so, list cell carrier:			☐	-
☐ Text Appointment Reminders				
☐ Text Office Specials				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

HIPAA Information and Consent Form

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.

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: _____

Photography Consent Form

Patient Name: _____ Date of Birth: _____

In connection with the medical services I have received from this office, Dr. Davis uses photography to gauge progress and healing. Your photos may also be used for marketing purposes, or for photo examples for patients seeking a similar procedure. Your consent waives all rights of compensation which may result in the use of your photograph. Please select below how you would like your photos to be used:

Internet, Media and/or Marketing: The photos may be used for marketing, media and advertisement purposes, such as internet posting, professional journal inclusion, brochures, or for informational seminars or lectures. Use of the photograph will not identify patient by name.

☐ YES ☐ NO

In-Office Use: The photos may be used to illustrate an example of a specific procedure to a prospective patient within the specific confines of the offices, or to be seen by a limited group of prospective patients at an assembly. Use of the photograph will not identify patient by name.

☐ YES ☐ NO

OR

Chart Use Only: I would like my photos to remain and be viewed in my chart.

☐ YES

Patient Signature: _____

E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

Patient Name: _____ Date of Birth: _____

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

• **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.

• **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events. Note that these databases may be incomplete if your pharmacy does not participate in database sharing. Neither will this list include over-the-counter medications and supplements/vitamins which you use. This list will not contain information on how well you utilized the prescriptions or why you may have stopped the prescription. Thus, we still need you to bring us a list of all medications and supplements which you use.

• **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or is partially filled.

• **Allergy** - To the degree you have supplied allergy information, this database should provide an allergy list but if you have developed an allergy which you have not told a participating pharmacy service about, it will not be listed. Thus, a complete list of your allergies, including the type of allergic reaction you experienced.

By signing this consent form you are agreeing that Davis Facial Plastic Surgery can request and use your prescription medication history from other healthcare providers, your pharmacy and/or insurers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Davis Facial Plastic Surgery to enroll me in the Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Signature: _____