



MEDICAL INFORMATION

Today's Date _____

Patient Name _____ Date of Birth _____ Age _____

Sex M F Height _____ Weight _____ lbs. Occupation _____

CHIEF COMPLAINT

Reason for today's visit: _____

Tests or treatments done for above complaint(s) _____

Please list: _____

MEDICAL / SURGICAL HISTORY

Do you have:

High Blood Pressure (Hypertension)? Diabetes? Thyroid disease? Heart Disease?

Please list any prior major illnesses and/or injuries:

Surgeries/Hospitalizations	Year	Complications?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had problems with anesthesia? Yes No

If "Yes", please describe: _____

Current Medication(s) including Aspirin/ Diet pills/ Herbal Supplements/Vitamins	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies/ Reactions to Medication, Anesthetics or Materials	Type of Reaction?
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Do you have a family history of trouble with anesthesia? Yes No

Do you have a family history of easy bleeding? Yes No

SOCIAL HISTORY

Do you smoke? Yes, I've smoked _____ packs of cigarettes per day for _____ years.

No, I have never smoked.

No, I quit _____ years ago, however I had smoked _____ packs per day for _____ years.

Do you chew tobacco? Yes, I have chewed for _____ years. How much do you chew? _____

No, I have never chewed tobacco.

No, I quit _____ years ago. Until then, I chewed _____ per day for _____ years.

Do you drink alcohol? No, never (or rarely)

No, but I used to.

Yes, I drink _____ drinks per (circle one) Day Month Week Year

REVIEW OF SYSTEMS

Do you currently, or have you had, problems with

Constitutional

- Weight gain
- Weight loss
- Night sweats
- Insomnia

Eyes

- Double vision
- Visual loss

Ear, Nose, Throat & Mouth

- Hearing loss
- Noise/ringing in ears
- Drainage from the ear R L
- Vertigo, Imbalance or dizziness
- Fullness or pressure in ear R L
- Nasal congestion
- Nasal drainage
- Difficulty breathing through nose
- Nose bleeds
- Cold Sores
- Frequent sinus infections
- Frequent sore throat
- Trouble swallowing
- Hoarseness
- Choking or coughing
- Throat clearing or gagging
- Frequent cough

Cardiovascular

- Chest pain or angina
- Heart trouble
- Heart murmur/Heart valve disease
- High blood pressure /Hypertension

Neurological

- Numbness
- Dizziness
- Stroke
- Headaches

Psychiatric

PREVENTION/WELLNESS

- Do you wear sunscreen daily and practice sun avoidance? Yes No
- Would you like more information about skin health and maintenance? Yes No

The above information is true to the best of my knowledge.

Patient Signature _____ Date _____

Physician Signature _____ Date _____

- Depression

- Anxiety Disorder

Allergic/Immunologic

- Sneezing
- Itchy eyes/nose /throat
- Skin rash or Hives
- HIV/AIDS

Respiratory

- Asthma
- Chronic cough
- Tuberculosis / Coughing up blood
- Pneumonia
- Trouble breathing at night
- Snoring

Gastrointestinal

- Stomach/bowel problems
- Bladder trouble
- Kidney disease

Musculoskeletal

- Arthritis

Endocrine

- Diabetes
- Thyroid disease

Hematologic

- Bleeding disorders
- Easy bleeding

Dermatologic

- Acne
- Skin Cancer
- Melanoma
- Other skin disorder

Other Medical conditions?

- _____
- _____
- _____
- _____



ADVANCED FACIAL PLASTIC SURGERY CENTER
Benjamin Bassichis, MD, FACS

PATIENT INFORMATION

Patient Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Preferred Telephone # _____ Alternate Telephone # _____
Sex M / F Social Security # _____ Marital Status _____
Email Address _____ Occupation _____
Employer _____ Work Telephone # _____
Work Address _____ City _____ State _____ Zip _____

How did you hear about us? _____

GUARDIAN INFORMATION (if applicable)

Name _____ Relationship _____ Date of Birth _____
Preferred Telephone # _____ Alternate Telephone # _____ Address
_____ City _____ State _____ Zip _____
Employer _____ Work Telephone # _____
Work Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Preferred Telephone # _____ Alternate Telephone # _____

REFERRING PHYSICIAN INFORMATION

Name of Physician _____ Office Telephone # _____
Office Address _____ City _____ State _____ Zip _____

DERMATOLOGIST INFORMATION

Name of Physician _____ Office Telephone # _____
Office Address _____ City _____ State _____ Zip _____

PRIMARY CARE PHYSICIAN INFORMATION

Name of Physician _____ Office Telephone # _____
Office Address _____ City _____ State _____ Zip _____

PRIMARY INSURANCE INFORMATION

Please attach a copy of/or bring insurance card(s), authorization forms, and picture I.D. to your office visit.

Primary Insurance Company _____ ID # _____

Group Number _____ Telephone # _____
Claim Filing Address _____ City _____ State _____ Zip _____
Insured Name _____ Relationship to Patient _____
Insured Social Security # _____ Insured Date of Birth _____
Insured Employer _____ Insured Work Telephone # _____

SECONDARY INSURANCE INFORMATION (if applicable)

Primary Insurance Company _____ ID # _____
Group Number _____ Telephone # _____
Claim Filing Address _____ City _____ State _____ Zip _____
Insured Name _____ Relationship to Patient _____
Insured Social Security # _____ Insured Date of Birth _____
Insured Employer _____ Insured Work Telephone # _____

INSURANCE AGREEMENT

I understand that I am financially responsible for charges not paid by my medical insurance and agree to pay these charges. I authorize any holder of medical information about me to release to any responsible health carrier, Texas Department of Insurance and/or the Social Security Administration or its intermediaries, any information for this or any related medical claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the ADVANCED FACIAL PLASTIC SURGERY CENTER for bills or services furnished to me.

Initial _____

FINANCIAL AGREEMENT

Fees for all services performed are determined by Dr. Bassichis alone. These fees are non-negotiable under any circumstance, by any party, and payment must be received at the time of service. We will not barter nor accept products or services in exchange for surgery or treatments. Should a balance appear on your account after the date of service for any reason, you will be notified and required to pay those charges within 90 days of that notice. If after 90 days payment has not been received, your account will be reviewed and sent to an outside collection agency. In the event a check is written for services rendered and does not clear your bank account, your balance will then be reinstated and a \$50 bounced check fee will be added.

Initial _____

AUDIOVISUAL CONSENT

I voluntarily give my consent to authorize photographic and/or video documentation for use in professional journals, medical books, or in the interest of medical education, research or other professional purposes. In accordance with Privacy Practices upheld by the ADVANCED FACIAL PLASTIC SURGERY CENTER, it is specifically understood that I will not be identified by name in association with my medical photographs.

Initial _____

ACKNOWLEDGEMENT

I have read and understand the above policies. I understand that all fees paid are nonrefundable unless deemed medically necessary by Dr. Bassichis. Proof of medical condition must be supplied to provide evidence of medical necessity and refund consideration

Signature _____ Printed Name _____ Date _____



ADVANCED FACIAL PLASTIC SURGERY CENTER

PATIENT COPY

PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. If you have any questions about this notice, please contact our Corporate Compliance and Privacy Officer at 14755 Preston Road, Suite 110, Dallas, TX 75254 or at 972-774-1777.

PURPOSE OF THIS NOTICE

This notice describes the ways in which we may use and disclose medical information about you. This notice also describes your rights and certain obligations we have regarding the use and disclosure of medical information.

OUR LEGAL REQUIREMENTS

We are required by law to

- Make sure that medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you;
- Follow the terms of the notice that currently is in effect;
- Change the notice only in accordance with federal rules; and
- Provide our internal complaint process for privacy issues to you.

WHO WILL FOLLOW OUR PRIVACY PRACTICES

This notice describes the practices of ADVANCED FACIAL PLASTIC SURGERY CENTER and that of

- All ADVANCED employees, staff and other ADVANCED personnel.
- ADVANCED affiliated entities and subsidiaries (all of which are collectively referred to as “ADVANCED”).

All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment, or health care operations purposes described in this notice.