MEDICAL INFORMATION Today's Date________________

Patient Name ____ Date of Birth _________________________ Age ______________

GUARANTOR INFORMATION Name_________________________ Relationship ____________________ Date of Birth: ___________

Phone # ____

SEX M F Height _____________ Weight ____________ Drug Allergies ____

Address ____ City ____________ State _____________ Zip ___________

Home Phone # ______________________________________ Cell Phone # ____

Social Security # _____________________________ Marital Status _____________________ Occupation ____________________

Email Address ____ **Would you like our Newsletter Specials? Y N**

Employer ____ Work phone # _______________________________________

Employer Address _____________________________________ City ______________ State ________________ Zip ____________

Preferred Contact Method ○ Home Phone ○ Cell Phone ○ Work Phone ○ Email

WHAT IS THE REASON FOR YOUR CONSULTATION WITH DR. BASSICHIS?

____

____

Please list any test, medications, previous surgeries or treatments done **FOR ABOVE COMPLAINT(S)**

____

How did you hear about us? ____

SOCIAL HISTORY

Do you smoke?

- Yes. I've smoked ___ packs of cigarettes per day for ___ year
- I am aware that smoking significantly increases the risk of surgical complications.
- 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've chewed for ___ years.
- 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 Week Month Year

Do you take recreational drugs?

- Yes. Type ________________ Frequency ______________
- No
- No, but I quit _____ years ago.

REFERRING PYSICIAN INFORMATION

Name of Physician ____ Office Phone # ____________________________________

Office Address ____ City_____________ State _____________ Zip _________

PRIMARY CARE PHYSICIAN INFORMATION

Name of Physician ____ Office Phone # ____________________________________

Office Address ____ City_____________ State _____________ Zip _________

DERMATOLOGIST INFORMATION

Name of Physician ____ Office Phone # ____________________________________

Office Address ____ City_____________ State _____________ Zip _________

MEDICAL/SURGICAL HISTORY

Do you have: ○ High Blood Pressure (Hypertension)? ○ Diabetes? ○ Thyroid Disease? ○ Heart Disease?

Medical history, illnesses and/or injuries:

____

Surgeries/ Hospitalizations	Year	Complications

Have you ever had a problem with anesthesia?○ Yes ○ No ○ Please Describe____________________________

Current Medications (including Aspirin/Diet Pills/Herbals Supplements/Vitamins)	Dose	Frequency	Reason

Allergies/Reactions to Medication, Anesthetics or Materials	Type of Reaction?
Any allergy/Problems to latex, medical tape, antibiotic ointment or other?	

FAMILY HISTORY

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

Do you have a family of easy bleeding Yes No

Please list any other pertinent family medical history? ____

PRIMARY INSURANCE INFORMATION

Please attach a copy of/or bring insurance card)s) authorization forms and Picture ID to your office visit

Primary Insurance:	
Insured Name:	Relationship to Patient:
Insured Social Security #:	Insured Date of Birth:

SECONDARY INSURANCE INFORMATION

Primary Insurance:	
Insured Name:	Relationship to Patient:
Insured Social Security #:	Insured Date of Birth:

PATIENT AGREEMENTS

AUDIOVISUAL CONSENT

I voluntarily give my consent to authorize photographic and/or video documentation for use in the medical record-keeping professional journals, medical books or in the interest of medical education, research or other professional purposes. In accordance with Privacy Practices strictly upheld by the ADVANCED FACIAL PLASTIC SURGERY CENTER, it is specifically understood that I will never be identified by name nor any private person information disclosed in association with my medical photographs. Initial: __________________

CANCELLATION POLICY

Please note that late cancellations within 24 hrs of your appointment or failure to appear for an appointment will incur a $75 cancellation charge for the physician and facial appointments; and $100 for the laser service appointments. Late cancelations or no-shows for surgical package appointment will forfeit that portion for the package. Insurance will not cover charges for no-show, late-cancellation fees.
We gratefully appreciate your consideration. Initial: ___________________

INSURANCE AGREEMENT

I understand that I am financially responsible for any charges not paid by medical insurance and agree to pay these charges. I authorize the release of my medical information to applicable health insurance carrier(s). Texas Department of Insurance and/or the Social Security Administration or its intermediaries, pertaining to this or any related medical claim(s). I permit copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the ADVANCED FACIAL PLASTIC SURGERY CENTER for bills or service furnished to me. **I also understand and acknowledge that I am personally responsible to pay ADVANCED FACIAL PLASTIC SURGERY CENTER in full for services that my health insurer will not cover due to non-payment for my health insurance premiums.**
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: ___________________

ACKNOWLEDGEMENT

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

REVIEW OF SYSTEMS

Do you currently, or have you had, medical problems with:

CONSTITUTIONAL
- Weight Gain
- Weight Loss
- Night sweats
- Insomnia

EYES
- Double vision
- Visual loss
- Dry eyes

EAR, NOSE, THROAT & MOUTH
- Hearing Loss
- Noise/ringing in ears
- Drainage from the ear R L
- Vertigo, Imbalance or dizziness
- Fullness or pressure in the ear R L
- Broken nose
- 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 disease
- Heart murmur/ Heart valve disease
- High blood pressure/hypertension
- Abnormal Stress Test
- Lightheadedness/ Fainting

NEUROLOGICAL
- Numbness
- Dizziness
- Stroke
- Headaches

PSYCHIATRIC
- Depression
- Anxiety Disorder
- Attention Deficit
- Bipolar Disorder
- Psychiatric illness or hospitalization

ALLERGIC/IMMUNOLOGIC
- Sneezing
- Itchy eyes/nose/throat
- Skin rash or Hives
- HIV/AIDS
- Immune disorder : _______________
- Hepatitis

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

GASTROINTESTINAL/RENAL (GENITOUTINARY)
- Stomach/bowel problems
- Bladder troubles
- Kidney Disease
- Reflux
- Hiatal Hernia

MUSCULOSKELETAL
- Arthritis

ENDOCRINE
- Diabetes I / II
- Thyroid Disease
- Other Endocrine disorder: ___________

HEMATOLOGIC
- Bleeding disorder
- Easy bleeding or bruising
- Anemia
- Blood clots

DERMATOLOGIC
- Acne
- Skin cancer
- Tendency for abnormal scar or keloid
- Other skin disorder
- Birthmarks
- Excessive hair or sweating
- Stretch marks
- OTHER MEDICAL CONDITIONS

CONFIDENTIALITY POLICY &**EMERGENCY CONTACT**

Patient Last Name: ____________________________ First Name: __________________________ Middle Initial: ____

Date of Birth: ___________________________________

1. Please list all family members or other personal representatives and their relation to you who may receive information about your medical condition and/or treatment

(I.e. pick up RX, reports, financial info **Emergency Contact**)

EMERGENCY CONTACT

Name	Relationship	Contact Phone #

2. Please circle the correct response: **HOME PHONE/VOICEMAIL WORKPLACE CELL PHONE**

Can appointment reminders be left? Yes No Yes No Yes No

Can confidential health information be left at the locations listed? Circle all that applies:

HOME PHONE/VOICEMAILWORKPLACECELL PHONE

PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORAMTION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCCESS TO THIS INFORAMTION. PLEASE REVIEW THIS NOTICE CAREFULLY BEFORE SIGNING THE AKNOWLEDGEMENT.

If you have any questions about this notice please contact our Corporate Compliance and Privacy Officer at 14755 Preston Rd #110 Dallas TX 75254 or at (972)774-1777

PURPOSE OF THIS NOTICE

This notice describes the way 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:

- Ensure that your protected health information that identifies you is kept private
- Give you 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
- Provide our internal compliant 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.

I agree that I have received a copy of the privacy practice document. If I have any questions, concerns or complaints, I will forward these to the Corporate Compliance and Privacy Officer whose contact information is located in the first paragraph of the Privacy Practices information.

Signature: ___________________________________ Printed Name: _______________________ Date : ___________

** Please let us know if you need a copy of our Privacy Policies**