NEW PATIENT INFORMATION

Today's Date: ____/____/____ **Date of Birth:** ____/____/____

Patient Name: _____ **Gender:** ☐ Male ☐ Female **Height:** _____ **Weight:** _____

Social Security #: ____-____-____ **Marital Status:** ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

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

Cell Phone: (____) _____ **Home Phone:** (____) _____ **Work Phone:** (____) _____

Occupation: _____ **Employer:** _____

Email Address: _____

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Emergency Contact: _____ **Relationship:** _____ **Phone:** (____) _____

Guarantor Name: _____ **Relationship:** _____ **Date of Birth:** ____/____/____

Preferred Pharmacy: _____ **Pharmacy Phone:** (____) _____

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

☐ Cosmetic ☐ Cosmetic/Insurance ☐ Injectables ☐ Skin Cancer Reconstruction ☐ MediSpa ☐ Insurance ☐ Research

How did you hear about us? _____

Referring Physician: _____ **Office Phone:** (____) _____

Referring Dermatologist: _____ **Office Phone:** (____) _____

Primary Care Physician: _____ **Office Phone:** (____) _____

INSURANCE INFORMATION (If Applicable)

Primary Insurance: _____

Policy Holder's Name: _____ **Relationship to Patient:** _____

Policy Holder's Date of Birth: ____/____/____ **Policy Holder's Social Security #:** ____-____-____

Secondary Insurance: _____

Policy Holder's Name: _____ **Relationship to Patient:** _____

Policy Holder's Date of Birth: ____/____/____ **Policy Holder's Social Security #:** ____-____-____

Please bring insurance card(s) and photo ID to your consultation.

MEDICAL/SURGICAL HISTORY

List Surgeries/ Hospitalizations	Year	Complications

Have you ever had a problem with anesthesia? ☐ Yes ☐ No Please Describe:_____

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

List Allergies to Anesthetics, Food, or Materials	Type of Reaction
Do you have an allergy/reaction to any of the following? **CIRCLE ALL THAT APPLY:** Latex Medical tape Antibiotic ointment	

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
Please list any other pertinent family medical history. _____

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 Month Week Year

Do you take recreational drugs?

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

REVIEW OF SYSTEMS

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

- Denies any Medical History

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

NEUROLOGICAL
- Numbness
- Dizziness
- Stroke
- Headaches

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
- Frequent sinus infections
- Frequent sore throat
- Trouble swallowing
- Hoarseness
- Choking or coughing
- Throat clearing or gagging
- Frequent cough
- Cold sores

CARDIOVASCULAR
- Chest pain or angina
- Heart disease
- Heart murmur/ Heart valve disease
- High blood pressure
- Abnormal Stress Test
- Lightheadedness/ Fainting

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

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

MUSCULOSKELETAL
- Arthritis

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

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

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

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

If you have any other medical problems not listed please explain: _____

_____

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:_____

PATIENT CONFIDENTIALITY POLICY & TREATMENT OF PRIVATE MEDICAL INFORMATION

We are committed to providing you with quality, personal health care. As part of our professional relationship, it is important that you understand our Patient Confidentiality Policy. Agreement with these policies is required for all medical services provided through ADVANCED FACIAL PLASTIC SURGERY CENTER.

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, medical reports, financial information):

Name: _____ **Relationship:** _____ **Phone:** (_____)_____

Name: _____ **Relationship:** _____ **Phone:** (_____)_____

2. Please indicate where confidential health information can be left (i.e. appointment reminders, test results):

☐ Home Phone/Voicemail ☐ Cell Phone/Voicemail ☐ Work Phone/Voicemail ☐ Email

PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION 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 Suite #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:** ____/____/____

Relationship to Patient, if Minor: _____

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