

**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: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

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: \_\_\_/\_\_\_/\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ CHECK ONE:  PPO Plan  HMO Plan

**\*\*IF HMO PLAN, PLEASE CONTACT YOUR PRIMARY PHYSICIAN FOR REFERRAL\*\***

**PLEASE EMAIL A PHOTO OF THE FRONT AND BACK OF YOUR INSURANCE CARD TO FRONTDESK@ADVANCEDFACIALPLASTIC.COM**

Secondary Insurance: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_/\_\_\_/\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ CHECK ONE:  PPO Plan  HMO Plan

**\*\*IF HMO PLAN, PLEASE CONTACT YOUR PRIMARY PHYSICIAN FOR REFERRAL\*\***

**PLEASE EMAIL A PHOTO OF THE FRONT AND BACK OF YOUR INSURANCE CARD TO FRONTDESK@ADVANCEDFACIALPLASTIC.COM**

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

**MEDICAL/SURGICAL HISTORY**

List Surgeries/ Hospitalizations	Year	Complications

**Have you been hospitalized or seen in the Emergency Room IN THE LAST YEAR?**  Yes  No

If yes, please describe: \_\_\_\_\_

**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 Medications, 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/day for \_\_\_ years
- 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 drink alcohol?**

- No, never (or rarely)
- No, but I used to.
- Yes, I drink \_\_\_ drinks per (circle one) Day Month Week Year

**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 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 cancellations 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 nonrefundable 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 ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY BEFORE SIGNING THE ACKNOWLEDGEMENT. 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\*\*