PREMIERE
CENTER for COSMETIC SURGERY

PLEASE COMPLETE AND RETURN TO THE FRONT DESK

NAME: LAST	**FIRST**				**M.I.**
ADDRESS (STREET OR P.O. BOX NUMBER:		**APT. #**	**CITY:**	**STATE:**	**ZIP:**
PHONE NUMBERS: DAY PHONE:	**EVENING PHONE:**		**CELLULAR PHONE:**		
EMAIL ADDRESS:			**SOCIAL SECURITY NUMBER:**		
SEX:	**BIRTH DATE:**	**AGE:**	**BIRTH PLACE:**	**MARITAL STATUS: ( )MARRIED ( )UNMARRIED ( )SEPARATED**	
OCCUPATION:	**EMPLOYER:**	**HOW LONG?**	**DRIVERS LICENSE #:**		
NEAREST RELATIVE NOT LIVING WITH YOU					
NAME: LAST:	**FIRST:**		**RELATIONSHIP:**		
PHONE NUMBERS: DAY PHONE	**EVENING PHONE**		**CELLULAR PHONE**		
EMERGENCY CONTACT INFORMATION					
NAME: LAST:	**FIRST:**		**RELATIONSHIP:**		
PHONE NUMBERS: DAY PHONE:	**EVENING PHONE:**		**CELLULAR PHONE:**		
GETTING TO KNOW YOU					
1. WHY DID YOU SELECT OUR OFFICE?					
2. WHO REFFERED YOU TO US? IF BY AN AD, WHICH ONE?					
3. HAVE YOU HAD PREVIOUS COSMETIC SURGERY? WHEN? WHAT?					
4. HAVE YOU CONSULTED WITH ANOTHER DOCTOR FOR THIS PROCEDURE?	**WHEN?**		**WITH WHOM?**		

PAYMENT ALTERNATIVES

- **Personal checks are accepted at least ten (10) business days prior to surgery.**
- **MasterCard, Visa, Discover, and American Express accepted.**
- **Payment financing: capital One, Surgery loans or Care Credit**

FOR ALL PATIENTS

I, _____represent to the physicians and staff that I am at least eighteen (18) years of age, or if not, I am accompanied by a legal guardian.

AUTHORIZATION FOR EXAMINATION: I authorize and consent to physical examination by the patient coordinator, the doctor, or any staff of PREMIERE Center for Cosmetic Surgery, designated by the doctor. I acknowledge and recognize that the Patient Coordinator and/or the sum of the staff of PREMIERE Center, who will or may conduct a physical examination of me, may not be medically trained persons. Nevertheless, I agree to be physically examined by the Patient coordinator and/ or staff members of PREMIERE Center for Cosmetic Surgery.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to e. a copy of this authorization shall be considered as valid as the original. For all elective, "fee for service" procedures I agree to pay for al services rendered by this office.

I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize the taking of photographs at the direction of my surgeon. These photographs will be used for documentation, peer review, and/or patient education. I, do or do not (circle one) authorize the use of my photographs for marketing purposes.

Signature of Responsible Party **Date**

MEDICAL INFORMATION

1. **Reason for Consultation:** _____

2. **List all previous surgeries/hospitalizations, including reason:**
   Surgery/Hospitalization/Reason
   _____ **General Anesthesia: ( )Yes ( )No**
   _____ **General Anesthesia: ( )Yes ( )No**
   _____ **General Anesthesia: ( )Yes ( )No**

3. **List all medications you are taking including eye drops and ointments.**

Medications	Dosage	How Often

4. **Check any of the following diseases which you have or have had:**

( ) Emphysema	**( )High/Low Blood Pressure**	**( ) Tuberculosis**
( ) Asthma	**( ) heart Murmur**	**( ) Cancer**
( ) Bronchitis	**( ) Irregular/Fast Heartbeat**	**( ) HIV/AIDS**
( ) Pneumonia	**( )Seizure Disorder/Epilepsy**	**( ) Angina**
( ) Stroke	**( ) Congenital Heart disease**	**( ) Rheumatic Fever**
( ) Glaucoma	**( ) Excessive Bleeding**	**( ) Thyroid Disorder**
( ) Diabetes	**( ) Stroke/ Heart Attack**	**( )Dry Eye Syndrome**
( ) Skin Cancer	**( ) Nervous Breakdown**	**( ) psychiatric Care**
( ) Cataracts	**( ) Liver Disease/Hepatitis/Jaundice**	**( ) Herpes/Genital?** _____

5. **Family History: List immediate family members either deceased (with cause of death and age) or living with serious illness:**
   _____
   _____
   _____
   Any family history of Breast Cancer? ( ) Yes ( ) No If yes, who? _____

6. **Private/Personal Physician:**
   Name: _____ **Phone:** _____
   Address: _____
   Date of last exam: _____ **Date of last EKG:** _____
   Last known Blood Pressure: _____ **Date of last Mammogram:** _____

7. **Social History: Please check and answer all of the following:**

Y	N	
( )	( )	**Do you have any skin problems? If yes, describe:** _____
( )	( )	**Do you smoke? If yes, how much per day?** _____
( )	( )	**Are you a former smoker? If yes, when did you stop?** _____
( )	( )	**Do you drink alcoholic beverages? If yes, how often?** _____
( )	( )	**Do you have vision problems? If yes, please explain.** _____
( )	( )	**Do you wear eyeglasses?** _____
( )	( )	**Do you wear contact lenses?** _____
( )	( )	**Do you wear removable dental appliances/dentures?** _____
( )	( )	**Do you now, or have you ever used 'street drugs'?** _____
( )	( )	**do you wear hearing aids?** _____
( )	( )	**Do you have allergies to medications or environments? If yes, explain.** _____
( )	( )	**Do you have allergies to latex or latex products? If yes, describe.** _____
( )	( )	**Do you have breathing problems? If yes, explain.** _____
( )	( )	**Do you have any disease, condition, or problem not listed that the doctor should know about? If yes, explain:** _____

_____

I HAVE READ (OR HAVE HAD READ TO ME) THE ABOVE MEDICAL INFORMATION LISTING AND I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS CORRECT, AND TO THE BEST OF MY KNOWLEDGE.

SIGN: _____ **DATE:** _____

PATIENT CONSENT FORM

Use and Disclosure of Health Information Protected under HIPAA

Pursuant to the information contained in the Notice of Privacy practices, I give permission for the use and disclosure of Protected Health Information (PHI) in order to carry out Treatment, payment and Healthcare Operations (TPO).

I am aware that I have the right to review the Notice of Privacy Practices prior to signing this consent. Should the Notice of Privacy Practices be revised, I am aware that I may obtain a copy of the revised form by contacting the medical Directors of this facility.

I give my consent for this organization to contact me by calling my home or other designated location in order to leave a message 9mechanically or with another person) or to speak to me directly regarding any matter which may help with the conduct of Treatment, payment, and Health Operations (TPO).

Further, I give my consent for the use of mail or e-mail to designated locations, including my home, to assist the organization in carrying out the described activities of Treatment, Payment, and Healthcare Operations (TPO).

I hereby consent to the use and disclosure of my PHI for the purpose of Treatment, Payment, and Health Operations (TPO). The consent is good until revoked in writing, except to the extent that disclosure has been made in reliance upon my prior consent.

Services are provided without regards to sex, race, color, religion, national origin, or disability.

Patient's Name:_____

Patient's Signature:_____

If applicable, Legal Guardian: _____

Date:_____