NEW IMAGE
COSMETIC SURGERY
& LASER CENTER

Patient Registration Form

Last Name: _____ First name: _____

Address: _____

City: _____ State: _____ Zip Code_____

D.O.B: _____ current age: _____ Social Security: _____

Marital Status: Single/Married/Divorced/Widowed Sex: Male/ Female

Home Phone: _____ Cell: _____ Work: _____

Family member contact: _____ Phone: _____

Next of kin: _____ Emergency contact: _____

Confidential Email: _____

Personal Physician (and phone number):_____

Current employer: _____What is your current occupation? _____

Were you personally referred by someone? _____

If not how did you hear about us? _____

What procedure are you interested in? _____

Have you ever had a cosmetic procedure before? _____

If so, what procedure, and when? _____

INSURANCE INFORMATION:

Insurance company: _____ policy #:_____

Group#:_____Insurance co mailing address: _____

I understand that the information contained within this questionnaire will be used as a basis to discuss with a consultant the recommendations regarding any surgical options performed and conducted by Physician , that may help improve my condition. Additionally I understand that there are certain health conditions that have contraindications which may prevent me from being treated. I have disclosed all of my current and past health conditions and understand a physician's release may be required for certain health conditions. I understand that the consultant is not a physician and will not provide any diagnosis or healthcare advice.

SIGNATURE: _____ DATE: _____

HEALTH QUESTIONNAIRE

Patient name: _____

Date of your last physical examination? _____ Patient height_____ Patient weight _____

How many children do you have? (Natural or C-Section?)_____

How is your general health?

_____

Who is your primary physician?

_____

What medical conditions are you presently being treated for?

_____

Please list your previous surgeries and any complications including anesthesia reactions:

_____

_____

Please list any reasons for hospital admissions:

_____

_____

Do any illnesses run in your family medical history? (Please include anesthesia and bleeding problems).

_____

Has any of your relatives had breast cancer? _____If so who?_____ last mammogram_____

Have you had a gastric bypass? _____ If so, when? _____

Please list all medications you are taking: _____

Are you allergic to any medications?

_____

Please list any and all allergies:

_____

Do you have any history or diagnosis of cancer? Yes ___ No____ If yes, please explain below.

Do you have any history of heart problems or disease? Yes ___No___ If yes, please explain below.

Do you have any history of Kidney or Liver disease? Yes _____No___ If yes, please explain below.

Do you have any history of Lymphatic disease? Yes____ No_____ If yes, please explain below.

Do you have a pacemaker or any other internal device? Yes___No___ If yes, please explain below.

Do you have anemia or sickle cell ? Yes___ No ___ If yes, please explain below.

Do you have HIV /Hepatitis? Yes___ No ___ if yes, please explain below.

If female, are you pregnant or breast feeding? Yes_____ No____ if yes, please explain below.

HEALTH QUESTIONNAIRE

PLEASE CIRCLE THE APPROPRIATE ANSWER

EYE

Eye pain YES/NO
Excessive tearing YES/NO
Visual changes YES/NO
Double vision YES/NO
Eye irritation YES/NO
Dry eyes YES/NO
Red eyes YES/NO
Glaucoma YES/NO
Contact lenses YES/NO
Sensitivity to light YES/NO
Visual loss YES/NO
Dry eyes YES/NO
Itchy or irritated eyes YES/NO
Blurred or double vision YES/NO
crossed or lazy eye YES/NO
cornea problems YES/NO
Thyroid eye disease YES/NO
Wear glasses or contacts YES/NO
Previous eyelid surgery YES/NO

EARS

Ear pain YES/NO
Ringing in the ear YES/NO
dizziness YES/NO
hearing loss YES/NO

NOSE

Post nasal trauma YES/NO
post nasal surgery YES/NO
difficulty breathing YES/NO
sinus problems YES/NO
previous nose injury YES/NO
nasal allergies YES/NO
nose bleeds YES/NO
previous nose surgery YES/NO

MOUTH

Dental problems YES/NO
tooth pain YES/NO
difficulty swallowing YES/NO
oral cancers YES/NO
Dentures YES/NO
Capped teeth YES/NO

CARDIOVASCULAR

High blood pressure YES/NO
congenital heart disease YES/NO
heart attack YES/NO
heart surgery YES/NO
irregular heart beat YES/NO
heart murmur YES/NO
chest pain YES/NO
Congestive heart failure YES/NO
foot/ankle swelling YES/NO
Rheumatic fever YES/NO
pacemaker YES/NO

RESPIRATORY

Asthma YES/NO
shortness of breath YES/NO
bronchitis YES/NO
pneumonia YES/NO
cough YES/NO
Tuberculosis YES/NO
chronic lung disease YES/NO

GASTROINTESTINAL

Peptic ulcers YES/NO
constipation YES/NO
hepatitis YES/NO
gastric reflux YES/NO
blood in stools YES/NO
jaundice YES/NO
indigestion YES/NO
black stools YES/NO
liver cirrhosis YES/NO
vomiting YES/NO
diarrhea YES/NO
change in bowel habits YES/NO

GENITOURINARY

Urinary tract infections YES/NO
frequent urination YES/NO
STD YES/NO
yeast infections YES/NO
difficulty urinating

MUSCULOSKELETAL

Injuries YES/NO
swelling YES/NO
extremity pain YES/NO
joint pain YES/NO
arthritis YES/NO
leg cramps YES/NO
difficulty walking YES/NO

NEUROLOGIC

Seizures YES/NO
stroke YES/NO
dizziness YES/NO
sensory loss YES/NO
weakness YES/NO

PSYCHIATRIC

depression YES/NO
alcoholism YES/NO
drug abuse YES/NO
anxiety YES/NO
marital problems YES/NO

HEMATOLOGIC

Bleeding disorders YES/NO
anemia YES/NO
easy bruising YES/NO
bleeding gums YES/NO
swollen lymph nodes YES/NO
sickle cell trait/disease YES/NO

IMMUNOLOGIC

HIV YES/NO
High risk sexual behavior YES/NO
History of blood transfusions YES/NO

ENDOCRINE

Diabetes YES/NO
Thyroid disorder YES/NO
hypoglycemia YES/NO
adrenal disorder YES/NO

FACE

Radiation to face YES/NO
facial paralysis or weakness YES/NO
acne or facial skin problems YES/NO
previous facial surgery YES/NO

PSYCHIATRIC

any recent crisis in your life YES/NO
been treated for depression YES/NO
been treated for anxiety YES/NO
received psychiatric treatment YES/NO
hospitalized for psychiatric treatment YES/NO

LIFESTYLE

Do you drink alcohol YES/NO
if yes how much per week _____
Do you smoke?
If yes how much per week _____
do you take recreational drugs YES/NO
If yes what kinds _____

BREAST

breast pain or discomfort YES/NO
breast cysts or lumps YES/NO
previous breast biopsies YES/NO
breast cancer YES/NO

SKIN DISEASE

rashes YES/NO
new or changing lesions YES/NO
skin cancers YES/NO

ALLERGIES

food allergies YES/NO
latex allergies YES/NO
steroids YES/NO
environmental allergies YES/NO
drug allergies YES/NO

WOMENS HEALTH

number of pregnancies: _____
live births: _____
miscarriages/abortions: _____
last menstrual period: _____
are you pregnant YES/NO.
last mammogram: _____
results: _____

OTHER

liver disease (hepatitis, cirrhosis) YES/NO
kidney or bladder problems YES/NO
history of blood cloths YES/NO
blood transfusions YES/NO
autoimmune disease YES/NO
unusual scarring YES/NO
spine or back problems YES/NO
history of cold sores or herpes simplex YES/NO

Patient's Bill of Rights and Responsibilities

Section 381.026, Florida Statutes, addresses the Patient's Bill of Rights and Responsibilities. The purpose of this section is to promote the interests and well being of patients and to promote better communication between the patient and the health care provider. Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows.

A patient has the right to:

- Be treated with courtesy and respect, with appreciation of his or her dignity, and with protection of privacy.
- Receive a prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for his or her care.
- Know what patient support services are available, including if an interpreter is available if the patient does not speak English.
- Know what rules and regulations apply to his or her conduct.
- Be given by the health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Be given full information and necessary counseling on the availability of known financial resources for care.
- Know whether the health care provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare. .
- Receive prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of an understandable itemized bill and, if requested, to have the charges explained.
- Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such research.
- Express complaints regarding any violation of his or her rights.

A Patient Is Responsible For:

- Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about his or her health.
- Reporting unexpected changes in his or her condition to the health care provider.
- Reporting to the health care provider whether he or she understands a planned course of action and what is expected of him or her.
- Following the treatment plan recommended by the health care provider.
- Keeping appointments and, when unable to do so, notifying the health care provider or facility.
- His or her actions if treatment is refused or if the patient does not follow the health care provider's instructions.
- Making sure financial responsibilities are carried out.
- Following health care facility conduct rules and regulations.

Patient Signature_____ Date:_____

New Image Cosmetic Surgery
(407) 226-0609
7350 Sand Lake Commons Blvd.
MedPlex B – Suite 1115
Orlando, FL 32819

New Image Cosmetic Surgery
1350 S. Orlando Ave.
Winter Park, FL 32789
Tel: 407-774-8001 Fax: 407-389-0825

Our notice of privacy practices provides information about how we may use and Disclose protected health information about you. The notice contains a patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the health Insurance portability and accountability act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- New image cosmetic surgery has noticed of privacy practices and that the patient has the opportunity to review this notice.
- New image cosmetic surgery reserves the right to change the notices of privacy policies.
- The patient has the right to restrict the uses of their information but
- New image cosmetic surgery does not have to agree to those restrictions.
- New image cosmetic surgery may condition treatment upon the execution of this consent.

_____ _____

Patient Signature or Authorized Person Witness Signature Date

If signed by person other than patient:

Name _____ Relationship to Patients _____ (must show proof of legal authorization to sign documents for patient)

Date: _____