PATIENT REGISTRATION FORM

☐ ***PATIENT INFORMATION***

Name: [First] ____________________________ [M.I] _______ [Last] _______________________________ ☐ Male ☐ Female

Address: _______________________________________ [Apt.] ___________________ Age: __________ DOB: _____/_____/_____

City: __________________________________ State: _________ Zip:_______________ Home #: (_____)______-________________

SSN: _____-_____-___________ Marital Status: ☐ Single ☐ Married ☐ Other Spouse Name: __________________________

Cell #:(_____)______-________________ E-mail: ____@_______________________

☐ ***May we leave personal medical information on your voicemail?*** ☐ ***Yes*** ☐ ***No / ☐ Home ☐ Cell***

☐ ***May we <u>TEXT</u> marketing & promotional information to you on your personal phone?*** ☐ ***Yes*** ☐ ***No***

Occupation: _____________________________ Employer: _________________________ Phone #: (_____)______-_____________

Pharmacy Name: _________________________ Phone #: (_____)______-________________Cross Streets: ____________________

☐ ***REFERRAL INFORMATION***

How did you hear about us? ☐ Google ☐ E-mail ☐ TV ☐ Social Media ☐ Physician ☐ Word of Mouth ☐ Other: _________________

Referring Provider: ____________________________________ Referring Patient: ____

Primary Care Physician: ____________________________ Phone #: ______________________ Fax #: _________________________

☐ ***REASON FOR VISIT***

Please describe what procedure(s) you are interested in: ____

____

Have you consulted with other physicians about the procedure(s) indicated above? ☐ Yes ☐ No

Is this a revision from a previous surgery? ☐ Yes ☐ No If yes, provide surgery and date: _________________________________

Do you have a time frame for the procedure you have indicated? ☐ Yes ☐ No If yes, when? ______________________________

☐ ***EMERGENCY CONTACT***

Name [Full Name]: ____ Relationship: _________________________________

Home #: (_____)______-________________Cell #: (_____)______-________________Work #: (_____)______-________________

Does this person have permission to discuss your private health information? ☐ Yes ☐ No

Patient / Responsible Party Signature: ____ Date: ___________________

☐ *I hereby certify the above information is true and correct to the best of my knowledge. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPAA guidelines. I understand that charges are payable on the day services are rendered.*

☐ ***PAST MEDICAL HISTORY –*** *Select if you have been diagnosed with any of the following medical conditions.*

ARIZONA
FACIAL PLASTICS P.C.

PATIENT REGISTRATION FORM

☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Cancer
☐ Chronic Sinusitis
☐ Depression
☐ Diabetes
☐ Ear Infections
☐ Hearing Loss
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV
☐ Irregular Heartbeat
☐ Kidney Stones
☐ Lupus
☐ Nasal Allergies
☐ Nasal Polyps
☐ Reflux
☐ Renal failure
☐ Seizures
☐ Sleep Apnea
☐ Stomach Ulcer
☐ Stroke
☐ Thyroid Deficiency
☐ Tuberculosis
☐ ____________________
☐ ____________________
☐ ____________________
☐ NONE

☐ ***PAST SURGERIES AND HOSPITALIZATIONS***

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ Yes ☐ No

If yes, please list problem and date: ____

Have you ever had facial plastic surgery? ☐ Yes ☐ No

If yes, please list surgery and date: ____

Have you been hospitalized for a medical problem before? ☐ Yes ☐ No

If yes, please list problem and date: ____

☐ ***SOCIAL HISTORY –*** *Select all that apply.*

☐ Currently smokes – daily ☐ Currently smokes – weekly ☐ **Has never smoked**

Started Smoking: ______________ Quit Smoking: _________________ # per Day: _____________ Total Years: __________

☐ Currently drinks – daily ☐ Currently drinks – weekly ☐ **Has never drunk**

Started Drinking: ______________ Quit Drinking: _________________ # per Day: _____________ Total Years: __________

☐ IV drug use ☐ Recreational drug use ☐ Caffeine use

☐ Patient feels safe at home ☐ Patient feels unsafe at home ☐ ____________________________

☐ ***REVIEW OF SYSTEMS –*** *Select ONLY if you are CURRENTLY experiencing any of the following.*

☐ Problems with bleeding
☐ Problems with healing
☐ Problems with scarring
☐ Immunosuppression
☐ Abdominal pain
☐ Bloody stool
☐ Bloody urine
☐ Blurry vision
☐ Chest pain
☐ Cough
☐ Face Pain
☐ Fever or Chills
☐ Headaches
☐ Hay fever
☐ Joint aches
☐ Muscle weakness
☐ Neck stiffness
☐ Night sweats
☐ Shortness of breath
☐ Sore throat
☐ Swollen glands
☐ Unwanted weight loss
☐ Vomiting
☐ Wheezing

Patient / Responsible Party Signature: ____ Date: ___________________

☐ *I hereby certify the above information is true and correct to the best of my knowledge. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPAA guidelines. I understand that charges are payable on the day services are rendered.*

☐ ***CURRENT MEDICATIONS –*** *This includes prescription, over-the-counter and* ***herbal*** *medications*

ARIZONA FACIAL PLASTICS P.C.

PATIENT REGISTRATION FORM

Are you taking ANY kind of medication now? ☐ Yes ☐ No If yes, please list below.

Name of Medication	Dose (Strength & # per Day)	Name of Medication	Dose (Strength & # per Day)

☐ ***ALLERGIES –*** *Please list ALL allergies. This includes medication and environmental, such as pollens, dust, food, etc.*

Are you allergic to anything that you are aware of? ☐ Yes ☐ No If yes, please list below.

Allergy	Type of Reaction	Allergy	Type of Reaction

☐ ***ALERTS -***

☐ Pacemaker
☐ Defibrillator
☐ Artificial joints within past 2 years
☐ Artificial heart valve
☐ Premedication prior to procedures
☐ Allergy to adhesive
☐ Allergy to topical ointments
☐ Allergy to lidocaine
☐ Blood thinners
☐ Blood transfusion
☐ Pregnancy or planning a pregnancy
☐ Rapid heartbeat with epinephrine
☐ Yeast infections with antibiotics
☐ ____________________________
☐ ____________________________

☐ ***ADDITIONAL NOTES AND EXPLANATIONS -***

____
____
____
____
____
____
____
____
____

☐ ***No Show, & Cancellation Fees*** - Please be respectful of the office's schedule. The fee for cancelling your treatment/appointment without 24 hours' notice of treatment or not showing for the appointment is **$50.00** plus the treatment fee.

Patient / Responsible Party Signature: ____ Date: ___________________

☐ *I hereby certify the above information is true and correct to the best of my knowledge. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPAA guidelines. I understand that charges are payable on the day services are rendered.*

Arizona Facial Plastics • 3102 East Indian School Road, suite 140 • Phoenix, AZ 85016
Phone: 480-296-0488 • Fax: 602-532-7273 • www.arizonafacialplastics.com

PATIENT REGISTRATION FORM

☐ **HIPAA ACKNOWLEDGMENT**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a Privacy Rule to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information and to carry out treatment, payment, or health care operations. By signing this document, I am stating that I have been provided a copy of the AZFP HIPAA policy. I also have the opportunity to authorize others to access my information according to the HIPAA guidelines. If you would like a printed copy of our HIPAA policy, please ask at the front desk.

I, (Print Full Name)____, give permission to AZFP to disclose the following protected health information to the following people/organizations listed below. This will allow us to discuss information including but not limited to appointments, payments, treatments, procedures, etc...) If patient wants spouse or other family members present in consultation, treatments, and aftercare appointments you will need to fill this portion out.

Family Member: ____ Relationship: ___________________

Name: ____ Relationship: ___________________

Name: ____ Relationship: ___________________

Legal Representative: ____________________________________ Relationship: ___________________

Information to be disclosed (check all that apply)

- ☐ Medical Records
- ☐ Treatment Records
- ☐ Diagnostic Records
- ☐ Billing Information
- ☐ Detailed Voice Mail
- ☐ Detailed Email
- ☐ Pictures/Video
- ☐ Appointments
- ☐ Other _________________

Finally, you may revoke this authorization in writing at any time by sending written notification to Arizona Facial Plastics at the address listed below. Your notice will not apply to actions taken by the requesting person/entity prior to the date we receive your written request to revoke authorization. This signature is good for the life of the patient's care at AZFP unless otherwise state.

Patient / Responsible Party Signature: ____ Date: ___________________

This authorization expires on _____/_____/_____ (optional)

PATIENT REGISTRATION FORM

☐ **Photograph & Text Consent**

I hereby acknowledge that I have been advised that photographs will be taken of me before and after surgery. The photographs will be taken by one of the members of the New Mexico Facial Plastics, P.C. medical staff. I hereby give my consent for Arizona Facial Plastics, PC to use the photographs under one of the following circumstances.

Please initial at least one of the following:

______ **Internet**: Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Arizona Facial Plastics, PC can be used on the company's website in order to inform the public about plastic surgery methods. Further, I release and discharge Arizona Facial Plastics, PC, any employees of Arizona Facial Plastics, PC, and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name or any other identifying marks at any time during any use or publication of these materials by any party.

_____ **All Media**: Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Arizona Facial Plastics, PC, can be used in any print or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet, and television, in order to inform the public about plastic surgery methods. Further, I release and discharge Arizona Facial Plastics, PC, any employees of Arizona Facial Plastics, PC, and the American Society of Plastic Surgeons; and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

_____ **Medical Care Only**: Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Arizona Facial Plastics, PC. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Arizona Facial Plastics, PC. By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other photo consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

Your health care is important to us. In order to provide you with the best possible care, we occasionally send convenient text messages to our patients about their health care and the products and services we offer. You are currently set to receive text messages for appointment reminders and information about your health care treatment and will receive text messages about promotions or other services we offer. If you wish to change your preferences, please indicate below. We look forward to providing better and more convenient communications with you via text messaging. Our goal is to provide you with relevant and useful information about your health care and the products and services we offer for improving your health.

☐ ***May we TEXT marketing & promotional information to you on your personal phone?* ☐ *Yes* ☐ *No***

Patient / Responsible Party Signature: ____ Date: ___________________