# Patient Information

## (Please Print Legibly & Fill In or Correct All Fields)

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| Patient Name  *Last First M.I.*  Address  *Street & Apt # City State Zip*  SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email  Home Phone Cell Phone  I give you permission to contact me by: □ Email □ Cell Phone  *Any restrictions contacting you? □* Yes *□* No *Contact Restrictions:*  Age Birthdate / / Gender: □ Male □Female  Primary Care Physician: Marital Status: □ Single □ Married □ Partner □ Widowed  Ethnicity: □ Caucasian □ African American □ Asian □ Native American  □ Hispanic or Latino □ Other:  Primary Language Spoken: |
| Patient’s Employer Occupation  Work Phone Ext: *Is it okay to call you at work? □ Yes □ No*  Work Address  *Street& Suite # City State Zip* |
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| Emergency Contact Relationship to Patient  Home Phone Cell Phone Work/Other Phone |
| I, the undersigned, consent to the use and disclosure of my protected health information for treatment, payment and operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act (HIPAA) without a written authorization. I accept that I am financially responsible for all services rendered on my behalf by **faces**, pllc. A copy of this agreement may be used in place of the original. I certify that the information stated on this form is  correct. |

### Signature Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient or Legal Guardian ONLY**

**Health Information**

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| Patient Name: Reason for Visit: Age: Height: feet inches Weight: lbs.  Who referred you to our practice? |
| **Do you have or have you had any of the following:** (Circle each) **If None Check Here □**  Abnormal Bleeding No/Yes Headaches/Migraine No/Yes Skin Cancer No/Yes Arthritis No/Yes Heart Disease No/Yes Skin Disease No/Yes Asthma No/Yes Heart Murmur No/Yes Sleep Apnea No/Yes Breast Cancer No/Yes Hepatitis No/Yes Stroke No/Yes Cancer (other) No/Yes High Blood Pressure No/Yes Thyroid Disorder No/Yes Chest Pain No/Yes High Cholesterol No/Yes Tuberculosis No/Yes Diabetes No/Yes HIV/AIDS No/Yes Ulcers (Gastric) No/Yes Fever Blisters No/Yes Kidney Disorder No/Yes Other  Hay Fever/Allergies No/Yes Sinus Problems/Infections No/Yes  Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **List All Medication Allergies:**  **□** No Known Allergies **□** Latex Allergy **□** Tape Allergy  Medication: Reaction: Medication: Reaction: Medication: Reaction: Medication: Reaction: |
| List ALL **(Prescription and Over-the-Counter)** Medications you are presently taking or have taken within the last month:  **□** No Current Medications  Medication: Dose: Medication: Dose: Medication: Dose: Medication: Dose: Medication: Dose: Medication: Dose: Medication: Dose: Medication: Dose: Medication: Dose: Medication: Dose: Medication: Dose: Medication: Dose: |

STANDING AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH DESIGNATED PERSONS

\*Not to be used in connection with health information from substance abuse treatment or mental health problems.

\*All items on this authorization must be completed or the request will not be honored. Use N/A if not applicable.

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| Patient Name: (first) (m. initial) (last) |
| For this authorization, “My Health Information” means any and all information relating to my course of examination and treatment. Including general information and inquires, arranging appointments, identifying medications, discussing billing and payment, insurance and any other related matter.  I authorize **f*a*ces, pllc** to discuss My Health Information with:  Name: Name: Relationship: Relationship: Phone Number: Phone Number:  I refuse permission to disclose my heath information to anyone with the exception of my  primary care physician and/or referring physician. |
| I understand that:   * This authorization is voluntary. My treatment will not be impacted, no matter if I sign this authorization or not. * If I do not sign this authorization, **f*a*ces**, **pllc** will not disclose my health information, with the exception of my primary care physician and/or referring physician. * This authorization is valid for as long as you are a patient with **f*a*ces**, **pllc**.   **If you wish to revoke this information you must request to fill out another authorization with updated information and a new signature.**   * Once my health information is disclosed as requested, it may no longer be protected by federal and state privacy(s) receiving it. * The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc. |

***Signature of Patient only: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Information**

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| **Family History:** Have any of your family members had any of the following? (Circle each; give family member if answer is yes)  No Relevant Family History No/Yes  Unknown – Adopted No/Yes  Autoimmune Disorder No/Yes Member:  Colon Cancer No/Yes Member:  Diabetes No/Yes Member:  Glaucoma No/Yes Member:  Heart Disease No/Yes Member:  High Blood Pressure No/Yes Member:  High Cholesterol No/Yes Member:  Liver Disease No/Yes Member:  Lung Disease No/Yes Member:  Malignant Melanoma No/Yes Member:  Obesity No/Yes Member:  Skin Cancer No/Yes Member:  Thyroid Disease No/Yes Member:  Scars/Keloids No/Yes Member: |
| **Surgical History:** List all surgeries and **Date** of occurrence, **especially facial procedures**:  Do you have any history of problems with Anesthesia? □ Yes □ No If yes, describe: |
| **Social History:**  **Smoking** (Please select one): □ Every Day Smoker □ Some Day Smoker □ Former Smoker □ Never Smoked  **Date Quit Smoking** (if applicable): **How much per day? Alcohol Use** (Please select one): □ No Alcohol Use □ Alcohol Use Daily □ Alcohol Use Socially |
| **Do you….**  Take Aspirin or anti-inflammatory daily? □ Yes □ No Dose  Use recreational drugs? □ Yes □ No If yes, describe: Have bleeding/bruising problems? □ Yes □ No If yes, describe: Have problems with scarring? □ Yes □ No If yes, describe: **Females ONLY:**  Are you pregnant or lactating? □ Yes □ No Are you going through menopause? □ Yes □ No  During pregnancy did you ever get hyperpigmentation or masking? □ Yes □ No |

**The above information is accurate and complete to the best of my knowledge.**

### Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_