


faces, pllc
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Patient Information

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

Patient Name _____			
<i>Last</i>		<i>First</i>	
<i>M.I.</i>			
Address _____			
<i>Street & Apt #</i>		<i>City</i>	<i>State</i>
<i>Zip</i>			
SS# _____	Email _____		
Home Phone _____	Cell Phone _____		
Any restrictions contacting you? <input type="checkbox"/> Yes <input type="checkbox"/> No Contact Restrictions: _____			
Age _____	Birthdate ____/____/____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Primary Care Physician: _____			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Widowed			
Ethnicity: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Native American			
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Other: _____			
Primary Language Spoken: _____			
Patient's Employer _____		Occupation _____	
Work Phone _____	Ext: _____	Is it okay to call you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Work Address _____			
<i>Street & Suite #</i>		<i>City</i>	<i>State</i>
<i>Zip</i>			
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

faces, pllc

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.

Patient Name: _____ <div style="display: flex; justify-content: space-around; width: 100%;">(first)(m. initial)(last)</div>								
<p>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.</p> <p>I authorize the faces, pllc to discuss My Health Information with:</p> <table style="width: 100%;"><tr><td style="width: 50%;">Name: _____</td><td style="width: 50%;">Name: _____</td></tr><tr><td>Relationship: _____</td><td>Relationship: _____</td></tr><tr><td>Phone Number: _____</td><td>Phone Number: _____</td></tr></table> <p><input type="checkbox"/> I refuse permission to disclose my health information to anyone with the exception of my primary care physician and/or referring physician.</p>			Name: _____	Name: _____	Relationship: _____	Relationship: _____	Phone Number: _____	Phone Number: _____
Name: _____	Name: _____							
Relationship: _____	Relationship: _____							
Phone Number: _____	Phone Number: _____							
<p>I understand that:</p> <ul style="list-style-type: none">• 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, faces, 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 faces, 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

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: _____

Health Information

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 _____