J. Randall Jordan, M.D.
Robin Ellis, MNA, CRNA
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1115 Highland Colony Parkway
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Patient Information

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

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*

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

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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:_______
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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: ____

(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 **faces, 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, **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

Family History: Have any of your family members had any of the following? (Circle each; give family member if answer is yes)

Condition	Answer	Member
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*_________________________