faces

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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*

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_____ Height: _____ Weight _____ 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:_____

Please let us know how you heard about Faces:

My friend _____ **Social Media** ☐ **Print Advertising** ☐

Other_____

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.

Please initial _____ Date _____

Health Information

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
Frequent 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:_____

Please initial _____ Date _____

Health Information

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.

Please initial _____ Date _____

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_____ **Date**_____