

Please initial ____

1115 Highland Colony Parkway Ridgeland, MS 39157

Phone: 601-607-3033 Fax: 601-853-4939

E-mail: faces@facesdr.com

<u>Patient Information</u> (Please Print Legibly & Fill In or Correct All Fields)

Patient Name				
	Last		First	M.I.
Address				
Street &	•	City	State	Zip
Email				
Home Phone			Cell Phone	
	0 , ,	•	□ Email □ Cell Phone ns:	
	ght: Weight nder: □ Male □Fem			
Primary Care Physic	cian:			
	ingle □ Married □ P			
Ethnicity:	aucasian	rican 🗆 Asian	□ Native American	
Primary Language Sp	oken:			
Please let us know how	w you heard about Faces:			
		_	☐ Print Advertising ☐	
Other			_	
Patient's Employer		Occupa	tion	
Work Phone	Ext:	Is it o	kay to call you at work? 🗆 Ye	s 🗆 No
Work Address				
	& Suite #	City	State	Zip
Emergency Contact_		Relat	onship to Patient	
Home Phone	Cell Phone		Work/Other Phone	
operations and such otl (HIPAA) without a writt	her purposes that are permi en authorization. I accept th	tted under the fe at I am financiall	d health information for treatme deral Health Insurance Portability responsible for all services rend inal. I certify that the information	y and Accountability Act lered on my behalf by

Date _____

Health Information

Do you have or have y	ou had any	of the following: (Circle	each)	If None Check Her	re 🗆
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		Other	
Hay Fever/Allergies		Sinus Problems/Infection	•		
Explain:					
List All Medication Al	lergies:				
		-			
☐ No Known Allergie	s □ La	atex Allergy	llergy		
NA - dia - dia -		D 11			
	Medication:Reaction:				
	Medication:Reaction:				
		Reacti			
Medication:Reaction:					
Medication:		Neacti	on:		
Medication:		neacti	on:		
		he-Counter) Medications			en within the
					en within the
List ALL (Prescription	and Over-th				en within the
List ALL (Prescription last month: ☐ No Current Medica	and Over-th	he-Counter) Medications	s you are pres		
List ALL (Prescription last month: ☐ No Current Medica Medication:	and Over-th	ne-Counter) Medications Dose:Med	s you are preso	ently taking or have take	_Dose:
List ALL (Prescription last month: No Current Medica Medication: Medication:	and Over-th	he-Counter) Medications Dose:MedDose:Med	s you are pressication:	ently taking or have take	_Dose:
List ALL (Prescription last month: No Current Medica Medication: Medication: Medication:	and Over-th	ne-Counter) Medications Dose: Med Dose: Med Dose: Med	s you are presonce ication:	ently taking or have take	_Dose: Dose:
List ALL (Prescription last month: No Current Medication: Medication: Medication: Medication:	and Over-th	ne-Counter) Medications Dose: Med Dose: Med Dose: Med Dose: Med	ication: ication: ication:	ently taking or have take	_Dose:
List ALL (Prescription last month: No Current Medica Medication: Medication: Medication:	and Over-th	ne-Counter) Medications Dose: Med Dose: Med Dose: Med Dose: Med Dose: Med	ication:ication:ication:ication:ication:ication:ication:ication:	ently taking or have take	_Dose: Dose:

Pl	ease	initial	Date		

Health Information

Surgical History: List all surgeries and Date of occurrence, especially facial procedures:					
Da var barra ann bistann af machlana	with America — Vec — No. If we describe				
Do you have any history of problems w	vith Anesthesia? Yes No If yes, describe:				
Social History:					
Smoking (Please select one): □ Every	y Day Smoker □ Some Day Smoker □ Former Smoker □ Never Smoked				
Date Quit Smoking (if applicable):	How much per day?				
Alcohol Use (Please select one): □ No	o Alcohol Use □ Alcohol Use Daily □ Alcohol Use Socially				
<u>Do you</u>					
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?					
Are you going through menopause?	□ Yes □ No				
Are you going through menopause?					
Are you going through menopause?	□ Yes □ No				
Are you going through menopause? During pregnancy did you ever get hype	□ Yes □ No				

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 face s	s, pllc to discuss My	Health Information with:			
Name:		Name:			
Relationship:	elationship: 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.					
 authorize If I do not the exce This authorize If you with upon the excension of the excen	norization is voluntar ation or not. ot sign this authorizar ption of my primary norization is valid for ish to revoke this inf dated information ar health information and state privacy(s) r lical information rele	is disclosed as requested, it may	myhealth information, with ohysician. In faces, pllc. Fill out another authorization In no longer be protected by elated to HIV status, AIDS,		

Date

Signature_____