lakeshore
FACIAL PLASTIC SURGERY

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Board Certified

Consultation & Medical Questionnaire

Name: ______________________________ Date: ____________

Home Phone: ____________________ Mobile: ____________________

Email: ____________________________ Date of Birth____/____/____

How did you hear about us? ______________________________

Did someone refer you to us; if yes, who? ______________________________

Primary care doctor: ______________________________

Reason for Visit *(please answer the following questions)*

What would you like to have corrected? ______________________________

Why are you interested in having this done? ______________________________

When did you first begin to consider plastic surgery? ______________________________

Have you had any other cosmetic procedures? ______________________________

Medical History *(please check all that apply)*

Eye History

YES	NO	
_____	_____	Dry Eyes
_____	_____	Visual Problems
_____	_____	Constant Tearing
_____	_____	Migraine Headaches

Nasal History

YES	NO	
_____	_____	Nasal Discharge
_____	_____	Nasal Congestion
_____	_____	Nasal Trauma
_____	_____	Sinusitis

General History

YES	NO	
_____	_____	Asthma
_____	_____	Diabetes
_____	_____	High Blood Pressure
_____	_____	Emphysema/Bronchitis
_____	_____	Cancer

YES	NO	
_____	_____	Heart Attacks
_____	_____	Chest Pain/Angina
_____	_____	Stroke/Mini Stroke
_____	_____	Shortness of breath
_____	_____	Difficulty walking up 2 flights of stairs

_____ _____ Connective tissue disease (Lupus, Rheumatoid Arthritis, etc.)

_____ _____ Smoking: Cigarettes/Cigars Number per Day ________ Number of Years __________

_____ _____ Alcohol Use: ______________________________

Medications

Are you currently taking birth control pills? **YES** or **NO**

Are you allergic to any medications? If YES, list all that apply:

____

Are you taking any medications? If YES, list all that apply including vitamins and herbs:

____

Surgical Questions

Have you ever had surgery on your face, neck, eyes or nose? If YES, please describe:

____

Have you ever had problems with Anesthesia? If YES, please describe:

____

Skin Type & Care

What is your ancestry? (i.e. Italian, English) ______________________

Have you ever had treatment for skin conditions? (i.e. Skin Cancer, Rosacea)__________

Please check if any of the following apply:

_____ Recent Acne

_____ Cold Sores

_____ Herpes/Shingles

_____ Scarring or Keloid Formation

_____ Poor Wound Healing

_____ Bleeding or Easy Bruising

_____ Blotchy Skin or Pigment Changes

_____ Radiation or Chemotherapy

Have you ever used any prescribed medication for your skin such as Accutane or Retin-A?

____

Have you ever had a chemical peel or facial resurfacing? If YES, please describe:

____

Are you currently using any skin care products: If YES, please list:

____

Do you regularly use sunscreen? **YES** or **NO**

Please choose the most appropriate statement:

_____ I always burn

_____ I tan without difficulty

_____ I can tan, but burn first

_____ I tan easily and rarely burn

NEW PATIENT REGISTRATION DATA

BASIC PATIENT INFORMATION

PLEASE PRINT LEGIBLY

Today's Date: ____________

Patient's Name: ______________________________ SS#: ____________
(Last) (First) (Middle)

Date of Birth: ____________

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Age: ____________

Address: ______________________________ Primary #: ____________ HOME WORK CELL

City: ____________ State: _____ Zip Code: ________ Secondary #: ____________ HOME WORK CELL

Responsible Party (if patient is minor): ______________________ Phone #: ____________

Emergency Contact: ______________________ Phone #: ____________
(Name) (Relationship)

Patient / Responsible Party E-Mail: ______________________________

Patient's Employer: ______________________ Work #: ____________

(Please Circle)

HOW DID YOU HEAR ABOUT US?

INTERNET FRIEND RELATIVE SELF YELLOW PAGES DOCTOR (please list below)

Referring Doctor: ______________________ Phone #: ____________

Address: ______________________________

Family Doctor (if different from Referring): ______________________ Phone #: ____________

Address: ______________________________

MEDICAL RECORDS

Name of person(s) to whom information may be released to other than the patient:

Name: ______________________________ Phone #: ____________
(Relationship to Patient)

INSURANCE INFORMATION

INSURANCE #1: ______________________

Policy Holder's Name: ______________________ SS #: ____________

Relationship to Patient: ______________________ Date of Birth: ____________

Policy #: ______________________ Group #: ____________ Co-Pay: ________

INSURANCE #2: ______________________

Policy Holder's Name: ______________________ SS #: ____________

Relationship to Patient: ______________________ Date of Birth: ____________

Policy #: ______________________ Group #: ____________ Co-Pay: ________

NOTIFICATION OF ACKNOWLEDGEMENT

I acknowledge that Lakeshore Ear, Nose, Throat Center, P.C. has offered me a copy of the "Notice of Privacy Practices" to read over or given me a copy:

Signature: ______________________________ Dated: ____________
(Patient / Personal Representative Signature) (Relationship)

(Payment is requested when services are rendered - Cash, Check, Credit Card - VISA, MASTERCARD OR DISCOVER.)

STATISTICS

We are required to report statistics on race, ethnicity, and preferred language(s) for our patient population. Your name, any other patient identifers or specifics will not be reported. We appreciate your participation in helping us collect this information.

Patient Last Name　　First Name　　Patient ID#:　　Date

ETHNICITY:
- ☐ Hispanic or Latino
- ☐ NOT Hispanic / Latino
- ☐ Unreported / Refused

RACE:
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Black / African-American
- ☐ American Indian / Alaska
- ☐ Native
- ☐ White
- ☐ More than one race
- ☐ Unreported / Refused

PREFERRED LANGUAGE:
- ☐ English
- ☐ Indian (including Hindi & Tamil)
- ☐ Spanish
- ☐ Russian
- ☐ Other
- ☐ Unreported / Refused

BARRIERS TO LEARNING

We want to make every effort to provide you with quality healthcare that meets all your needs. Please let us know if you have any of the below barriers that could prevent us from understanding and / or providing your medical needs.

☐ NO BARRIERS TO LEARNING

- ☐ Vision
- ☐ Emotional
- ☐ Cultural
- ☐ Written Language
- ☐ Financial
- ☐ OTHER: ____________________
- ☐ Disease
- ☐ Cognitive Disability

☐ SPOKEN LANGUAGE: ____________________
LANGUAGE (OTHER THEN AMERICAN-ENGLISH) THAT I WOULD PREFER TO COMMUNICATE

☐ HEARING: ____________________
(THE OFFICE CAN MAKE AN A.L.S. INTERPRETER AVAILABLE FOR YOUR APPOINTMENT)

ADVANCED MEDICAL DIRECTIVE

This is a document used by patients to communicate their wishes regarding medical care they wish to receive if unable to speak for themselves.

Do you have an Advanced Medical Directive (Living Will)? ☐ Yes ☐ No

(OFFICE STAFF TO COMPLETE)
Is a copy of the Advanced Medical Directive in the patient chart? ☐ Yes ☐ No

A department of

ST. JOHN HOSPITAL & MEDICAL CENTER

Lakeshore Facial Plastic Surgery

PRIVACY PRACTICES STATEMENT

ACKNOWLEDGEMENT OF RECEIPT

PLEASE PRINT

Patient Name (print): ______________________________ Acct#__________________

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION:

By law, we are only authorized to speak with the patient regarding any form of private healthcare information, which includes scheduled appointments, test results, medication, your office visit, and surgery.

Please check below:

______I give Lakeshore Facial Plastics, authorization to speak with my immediate family, or persons which I specify below, regarding my private healthcare information.

____

____

______I do not authorize Lakeshore Facial Plastic Surgery, to speak to anyone regarding my private healthcare information.

____________________________________ ____________________

Patient or Personal Representative Signature Date

COMPUTERIZED PRESCRIPTION PROGRAM

Dear Patient:

For your convenience and safety, we are introducing a computerized prescription program that will improve both the accuracy and convenience of prescribing medications. This program will allow for the electronic transmission of most of your prescriptions directly to your pharmacy of choice, and will eliminate your waiting time. In most cases, it will also accommodate the transmissions of your prescriptions to mail order pharmacies.

In order to implement this new program, we need to collect some information from you on your pharmacies of choice. We will define one pharmacy as your main pharmacy; however, you may also provide the information for additional pharmacies to be used as an alternative. In addition, if you have a mail order benefit program, please provide that information by selecting the appropriate box below.

We understand that you may not have the complete pharmacy information with you today. Please provide any information possible regarding the location (street, city, phone, fax), as any information provided will be helpful.

PATIENT'S NAME:______________________________ **DATE OF BIRTH:**__________

MAIN PHARMACY:

Name (i.e., CVS, Rite-Aid, etc.):______________________________
Street Name & City:______________________________
Phone:______________________ Fax:______________________

ADDITIONAL PHARMACIES YOU WOULD LIKE KEPT ON FILE:

Name (i.e., CVS, Rite-Aid, etc.):______________________________
Street Name & City:______________________________
Phone:______________________ Fax:______________________

Name (i.e., CVS, Rite-Aid, etc.):______________________________
Street Name & City:______________________________
Phone:______________________ Fax:______________________

MAIL ORDER:

❑ Medco ❑ CareMark ❑ Express Scripts, Inc. ❑ Pharmacare

Please list your drug allergies:______________________________
____
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