NEW PATIENT INFORMATION

Today's Date _____ • Male ☐ Female ☐ • Date of Birth (*mm/dd/yyyy*) _____ • Age _____

Name: _____
(first) *(middle initial)* *(last)*

Address: _____
(street) *(city)* *(state)* *(zip code)*

Home Phone # (*land line*) : _____ Mobile #: _____ ☐ confirmation calls/texts?

Work #: _____ Occupation: _____ Employer: _____

Email: _____
(we use email frequently to communicate appointment information and do NOT send solicited material)

• Name of referring physician (*if applicable*): _____
• Referred from one of our existing patients? If so, we would love to know and show our appreciation!
Name: _____ | Do we have your permission to send them a thank you card? ☐
• How did you hear about us if not from a particular person? _____ Internet
_____ Other

Race (*check one if applicable*) **OPTIONAL**
_____ Caucasion _____ Hispanic _____ East Indian
_____ African American _____ Asian _____ NOT Hispanic or Latino

Language *(check all that apply)*
_____ English _____ Spanish _____ Korean _____ Mandarin
_____ Cantonese _____ Vietnamese _____ Russian _____ Other: _____

Relationship/Marital Status:
_____ Single
_____ Married | Spouse - name: _____ | *Also your emergency contact?* ☐
Spouse - phone #: _____
*Other Relationship Status (*if you would like to include for your file*): _____

Emergency Contact: _____ Phone: _____Relationship to you: _____

INSURANCE

Primary Insurance Company: _____ ID# _____ Group # _____
Insured Name: _____ DOB _____ SS # _____

Secondary Insurance Company: _____ ID# _____ Group # _____
Insured Name: _____ DOB _____ SS # _____

I hereby authorize payment of any surgical and/or medical benefits directly to the physician for services. I also agree to pay all charges that exceed or are not covered by insurance and authorize release of information to the insurance company. I also authorize the physician to disclose information to those individuals qualified for the purpose of medical quality assurance and peer review.

Signature: _____ **Date**: _____

HISTORY & PHYSICAL

Patient Name _____ Date of Birth: ___/___/_____ Today's Date _____

Primary Concern(s) | What brings you in today?

_____

_____

Last Botox/Filler Treatment (date/provider):_____

Latex Allergy (if known): □ Yes □ No

Medication/Drug Allergies: □ None □ Yes if yes, please list the drug(s) and reaction below:

_____

_____

Have you ever had any of the following?

□ Heart disease/Heart Murmur
□ Mitral valve prolapse
□ High blood pressure
□ Thyroid Disease
□ Anemia
□ Hepatitis or HIV
□ Herpes (cold sore, genital or shingles)
□ Diabetes
□ Acid reflux disease
□ Problems w/ anesthesia
□ Asthma
□ Sleep apnea/snoring
□ Migraines/headaches
□ Stroke/TIA
□ Psychiatric care
□ Arthritis
□ Cancer (of_____)
□ Other_____

Have you recently had any of the following?

□ Fever, chills, nausea, vomiting or diarrhea
□ Weight increase or decrease
□ Skin rashes or lumps
□ Frequent colds, sinus congestion
□ Changes in vision or hearing
□ Sore throat or bleeding gums
□ Lumps in neck
□ Breast masses, nipple discharge
□ Chest pain or shortness of breath
□ Difficulty breathing
□ Numbness, tingling, cramping in hands or feet
□ Swelling in the hands or feet
□ Seizures, paralysis
□ Anxiety
□ Depression
□ Heartburn or abdominal pain
□ Other_____

Patient to Complete: Height:_____Weight:_____

Known Drug Allergies & Reactions:_____

Previous surgeries (please list Surgeon name/Procedure/Date of surgery)

_____

_____

Prior hospitalizations/illnesses & date(s):

_____

Current medication(s) (Please list frequency & dosage information):

_____

_____

Significant family medical history:

_____

_____

Alcohol Consumption:
___ I never consume alcoholic drinks
___ I occasionally consume alcoholic drinks | approximately _____ drinks(s) per month
___ I regularly consume alcoholic drinks | approximately _____ drinks(s) per week

Exercise/Activity Level _____
_____

Type of Employment/Environment *(ie: full time desk job; construction; homemaker; etc...)*
_____

I hereby declare that the information I have provided on this form is a true and accurate record to the best of my knowledge.

PATIENT SIGNATURE _____ Date _____

Reviewed/Witnessed by _____ Date _____

SMOKING RISK CONSENT

I have been advised by Dr. James Ridgway and his staff that I must not smoke or take nicotine substitutes for a ***minimum of six (6) weeks before my surgery***. I have also been advised that being in the presence of secondhand smoke can compromise my surgery and its outcome. It has been explained to me that the risks of surgery are much greater for smokers and even if I am off cigarettes AND all nicotine substitutes for six (6) weeks before and after surgery, I may still experience the effects of nicotine.

- ☐ I am NOT a smoker.
- ☐ I no longer smoke regularly. I quit _____weeks/months/years ago.
- ☐ I currently smoke _____ a day.

There is greater risk in smokers for bad scarring, hematoma formation, intraoperative bleeding, bleeding, poor or delayed healing, hair loss, sloughing of the skin (skin loss), infection, increased or prolonged bruising and hyperpigmentation.

I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO OPERATE, THAT THE RISKS HAVE BEEN FULLY EXPLAINED TO ME AND I WISH TO PROCEED WITH SURGERY.

Patient Signature _____ Date _____ | Witness _____ Date _____

To be completed by RN:

VITALS: BP _____ HR _____ T _____ 02 sat _____ height _____ weight _____

AUTHORIZATION TO RELEASE INFORMATION

If requested, I, _____, authorize my information to be shared with:

(Patient Name)

1) Name _____ Phone _____ Relationship _____

2) Name _____ Phone _____ Relationship _____

3) Name _____ Phone: _____ Relationship _____

**NO ONE _____

Regarding the **initialed** items below, I understand that by signing this form only the person(s) designated above are allowed to obtain my information and they are **only** allowed to obtain information regarding the items that I have designated below. By **initialing** beside **"ALL INFORMATION"** I understand that the person(s) listed above will be granted access to obtain all of my medical and personal information that the office of Ridgway Face & Aesthetic Center has on file. I understand that this written authorization will remain in my permanent record and will not change at any time unless I issue a written consent to discontinue and/or change this authorization.

_____ APPOINTMENT DATES/TIMES | _____ TEST RESULTS | _____ INSURANCE INFORMATION |

_____ **ALL INFORMATION** | _____ OTHER:_____

_____

Patient Signature Date

Patient Name _____

PATIENT PHOTOGRAPH CHART CONSENT

I hereby grant permission for Ridgway Face & Aesthetic Center and its designated representatives to take and use any pre-operative or post-operative photographs of myself for purposes of my medical record only. If my photos were to be used for: research, education and medical publications as well as advertising, I would be asked to sign a different release form giving my explicit consent for those purposes. I understand that no form of compensation shall become payable to me for the use of photographs. I further understand no names, birth dates or private information will be disclosed.

Signature _____ | Date _____

**If patient is under 18 years of age or requires signature of a legal guardian:

Name _____ | Relationship to Patient _____

Signature _____ | Date _____

ACKNOWLEDGMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed that I have rights to privacy regarding my protected health information, and I have been given the opportunity to review this office's *Notice of Privacy Practices* as required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Provide and coordinate treatment among health care providers who may be involved in my care
2. Obtain payment from third-party payers for my health care services
3. Conduct normal health care operations

Signature _____ Date _____

**If patient is under 18 years of age or requires signature of a legal guardian:

Name _____ | Relationship to Patient _____

Signature _____ | Date _____