NEW FACE NY

# RICHARD W. WESTREICH, MD, FACS

## FACIAL PLASTIC, RECONSTRUCTIVE & NASAL SURGERY

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**NAME**

**SEX** **M** **F**

**DOB**

**MARITAL STATUS** **S** **M** **W**

**HEIGHT:** **WEIGHT:**

**HOME ADDRESS**

**PREFERRED PHONE #** **ALTERNATE PHONE#**

**EMAIL ADDRESS**

**EMERGENCY CONTACT NAME & TELEPHONE**

**EMPLOYER NAME**

**PHARMACY NAME & TELEPHONE**

**PRIMARY PHYSICIAN**

**REFERRING PHYSICIAN**

**HOW DID YOU FIND US?** PHYSICIAN _____ GOOGLE _____ FRIEND _____

INSTAGRAM _____ FACEBOOK _____ OTHER _____

**HAVE YOU SEEN OUR WEBSITE NEWFACENY.COM?** Y N

**HAVE YOU SEEN OUR INTAGRAM PAGE, NEWFACENY.COM?** Y N

**BEAUTYBYNEWFACENY.COM?** Y N

NEW FACE NY

# HEALTH QUESTIONNAIRE

| PAST MEDICAL HISTORY | | | DETAILS |
|---|---|---|---|
| HEART DISEASE | Y | N | |
| HYPERTENSION (HIGH BLOOD PRESSURE) | Y | N | |
| PULMONARY/ LUNG ISSUES/ASTHMA, COPD | Y | N | |
| DIABETES | Y | N | |
| THYROID DISEASE | Y | N | |
| STROKE OR NEUROLOGICAL | Y | N | |
| SLEEP APNEA | Y | N | |
| BLEEDING DISORDER | Y | N | |
| KIDNEY DISEASE | Y | N | |
| IMMUNE DISORDER | Y | N | |
| CANCER HISTORY | Y | N | |
| PSYCHIATRIC ILLNESS | Y | N | |
| HISTORY OF COVID-19 | Y | N | |
| **CURRENT MEDICAL SYMPTOMS** | | | |
| WEIGHT CHANGE | Y | N | |
| FEVER/FATIGUE | Y | N | |
| NASAL OBSTRUCTION | Y | N | |
| RUNNY NOSE | Y | N | |
| POST-NASAL DRIP | Y | N | |
| HEADACHES | Y | N | |
| CHEST PAIN | Y | N | |
| COUGH/SHORTNESS OF BREATH | Y | N | |
| REFLUX | Y | N | |
| SKIN RASH/LESIONS | Y | N | |
| ARTHRITIS, JOINT PROBLEMS | Y | N | |
| HEAVY BRUISING/BLEEDING | Y | N | |
| MUSCLE WEAKNESS | Y | N | |
| MEMORY LOSS | Y | N | |
| VISUAL CHANGES | Y | N | |
| HEARING LOSS | Y | N | |
| THROAT OR VOICE PROBLEMS | Y | N | |
| DENTAL ISSUES | Y | N | |
| CURRENT USE OF ILLEGAL DRUGS | Y | N | |

NEW FACE NY

# HEALTH QUESTIONNAIRE

| | | | |
|---|---|---|---|
| **ALLERGIES TO MEDICATION** | **Y** | **N** | **SPECIFY:** |
| **ALLERGIES TO LATEX** | **Y** | **N** | |
| **ALLERGIES TO TREE NUTS** (Almonds, Cashews, Pecans, Pistachios, Walnuts) | **Y** | **N** | |
| **CURRENT OR PAST SMOKER** | **Y** | **N** | **IF FORMER, YEAR QUIT?** |
| **(WOMEN) PREGNANT OR NURSING?** | **Y** | **N** | |
| **NEGATIVE REACTION TO ANESTHESIA** | **Y** | **N** | **SPECIFY:** |

**MEDICATION HISTORY**
(SUPPLEMENTS)

| **SURGICAL HISTORY** | **YEAR** | **SURGERY** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**FAMILY HISTORY OF DISEASES OR CONDITIONS**

**ADDITIONAL INFORMATION YOU WOULD LIKE DR. WESTREICH OR HIS STAFF TO KNOW**

**AUTHORIZATION FOR INSURANCE** I authorize the release of any medical or personal information as is necessary to process this claim based upon the "HIPAA notice of Privacy Practices" information provided to me under separate cover. This information is on file as a permanent record and may be amended as is necessary

**SIGNATURE** **NAME** **DATE**

NEW FACE NY

**NEW PATIENT COSMETIC QUESTIONNAIRE**

**Do you have any interest in learning about treatment for any of the following concerns:**

☐ Skin tone/ hyper or hypo pigmentation

☐ Skin laxity on face/ body

☐Fat loss on face/ body

☐ Skin texture

☐ Fine lines/ wrinkles

☐ Hair loss or thinning

☐ Cellulite

[redacted]

☐ Volume loss in face

☐ Nose reshaping

☐ Ear pinning

☐ Veins

☐ Hand aging

☐ Acne on face or body

_____ _____

**SIGNATURE** **DATE**

NEW FACE NY

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**
**(HIPPA)**

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among multiple health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers
- conduct normal healthcare operations such as quality assessments and physician's certifications

**Please select one:**

☐ I have received, read, and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

☐ I decline to receive a new copy of the Notice of Privacy Practices, as I have previously received it.

**By signing this, I understand:**

- This organization has a right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

- I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations.

- I also understand that you are not required to agree with these requested restrictions. However, if you do agree then you are bound to abide by such restrictions.

I designate other individuals, who may be contacted about my private health information:

_____

_____ _____

**NAME** **SIGNATURE**

_____ _____

**RELATIONSHIP (if not patient)** **DATE**

NEW FACE NY

**OFFICE CANCELLATION POLICY**

We are fortunate that the office has a high demand for patient appointments. Our office, as a policy, does not overbook and makes every attempt to create a schedule which will remain, in most instances, on time. In order to ensure that every patient has fair access to schedule a timely appointment, we have adopted the following policy towards last minute cancellations and no shows.

We expect our patients to inform us of changes to their schedule. While your personal reasons may vary, the ultimate result of a late cancellation or no show is time that another patient was not given for their personal health needs.

1. Please provide a courtesy call if you are running more than 10 minutes late. If you are more than 15 minutes late, it may result in the cancellation and rescheduling of your appointment.

2. For non-emergent circumstances, we expect 2 business days notice of cancellation for routine appointments. If compelling issues are present, please let the office know.

3. Canceling your appointment in an untimely manner will result in the following charges prior to rescheduling:

    a. **$50 Late fee for canceling less than two business days.**
    b. **$100 same day no-show fee.**
    c. **Consultations will forfeit their consultation fee**

4. Deposits:

    a. New patients: a deposit will be required to reserve your appointment; this will go towards your service.
    b. Existing patients: will be required to have an updated credit card authorization form on file. You will be asked again within a 6-month period, to ensure accurate, updated information is on file.

_____ _____ _____

**SIGNATURE** **PRINT** **DATE**