ROUSSO FACIAL PLASTIC SURGERY CLINIC, P.C.

CONSULTATION AND MEDICAL HISTORY

Name _____ Date of Birth _____ Today's Date _____

Address: Home _____ _____ _____ _____ _____

Street City State Zip telephone

Cell Phone: _____ Email Address: _____

Business _____ _____ _____ _____ _____

Street City State Zip telephone

Marital Status: S M D W Spouse's Name _____

Your Occupation/Employer _____ Spouse's Occupation/Employer _____

How were you referred to us? _____ Name of family members who are our patients (type below)

_____

In which surgical procedure (s) are you interested in? (Please circle/check)

☐ Facelift	☐ Rhinoplasty	☐ Chin	☐ Eyelids
☐ Septoplasty	☐ Chemical Peel	☐ Dermabrasion	☐ Laser Resurfacing
☐ Microdermabrasion	☐ Scar Revision	☐ Protruding Ears	☐ Hair Transplants
☐ Laser Hair Removal	☐ Botox Injection	☐ Facial Reconstruction	☐ Removal of Cyst, Warts, Moles
☐ Removal of Brown Spots	☐ Removal of Facial Veins	☐ Micro Laser Peel	☐ Restylane/Sculptra/Radies

Other _____

When did you begin to consider surgical correction? _____ Why have you decided to have it done at this point in time?

_____

Have you consulted any other doctor about this? Y N When? _____

Have you discussed this surgery with your family? Yes ☐ No ☐ Are they agreeable? Yes ☐ No ☐

Have you had any previous cosmetic, plastic or reconstructive surgery? Y N When, and what, if anything was done? _____

_____

Who performed the surgery? _____ Where was it performed? _____ Were you satisfied with the results? Y N

If not why? _____

If injury, describe injury? _____

Date of injury? _____ Place of injury? _____ Treatment received? _____

_____

Do you have problems breathing through your nose? Y N Do you have sinus problems? Y N

Have you had nasal trauma? Y N When? _____ Describe: _____

Has anyone in your family or a close friend had cosmetic, plastic or reconstructive surgery? Y N

What was done? _____ By Whom? _____

Have you had any other prior surgery? Y N When was it performed? Head & Neck _____

Skin _____ Teeth/Gums _____ Chest _____ Abdomen _____

Reproductive system _____ Back/Arms/Legs _____ Other _____

Did you have a normal recovery? Y N Did the results meet your expectations? Y N

If no explain _____

Who is your primary physician? _____ Telephone _____

Address _____ City _____ State _____

May we have your permission to consult with your physician? Y N

(over)

MEDICAL HISTORY (Check appropriate response)

No ☐ Yes ☐ Are you now taking any drugs or medications? (How often?)
List them if you can

No ☐ Yes ☐ Are you allergic to any medication, cream, tape, make-up, etc?
List them if you can

No ☐ Yes ☐ Have you ever received local anesthesia ("Novocaine, Xylocaine") by a dentist or doctor?

No ☐ Yes ☐ Did you have a "reaction" to any anesthesia? Explain

No ☐ Yes ☐ Do you or any family members have:(indicate who)
Heart trouble ____ Excessive bleeding tendencies ____
High Blood Pressure ____ Diabetes ____
Thyroid Problems ____ Psychiatric or "nerve" problems ____
Excessive bruisability ____ Excessive Scarring ____
Delayed or poor healing ____ Other ____

No ☐ Yes ☐ Do you have any history of bleeding: (indicate which)
From the nose ☐ In the Urine ☐ Vomiting blood ☐
From the rectum ☐ Coughing up Blood ☐ Other: ____

No ☐ Yes ☐ Do you have or have you had nasal allergies, "sinus problems", asthma or hay fever? (Explain below)

No ☐ Yes ☐ Do you have or have you had any problems with your eyes or vision? Explain

No ☐ Yes ☐ Has a doctor ever said you had "heart trouble"? Explain

No ☐ Yes ☐ Do you have "stomach trouble" or ulcers? Explain

No ☐ Yes ☐ Do you have or have you had chest or lung problems? Explain

No ☐ Yes ☐ Have you ever had liver, gall bladder trouble or "yellow jaundice? Explain

No ☐ Yes ☐ Have you been bothered by kidney or bladder problems? Explain

No ☐ Yes ☐ Do you have frequent skin infections, irritation or rashes? Explain

No ☐ Yes ☐ Have you ever had fever blisters or "cold sores" or Canker sores on your face, lips or in your Mouth or Genital Herpes? Explain

No ☐ Yes ☐ Do you often have severe headaches or dizzy spells? Explain

No ☐ Yes ☐ Has any part of your body ever been paralyzed or numb? Explain

No ☐ Yes ☐ Did you ever have a convulsion or seizure? Explain

No ☐ Yes ☐ Were you ever told you had any venereal disease or AIDS? Explain

No ☐ Yes ☐ Were you ever treated for anemia or any problems with your blood? Explain

No ☐ Yes ☐ Have you ever taken hormones or thyroid medication? Explain

No ☐ Yes ☐ Do you smoke?

No ☐ Yes ☐ Do you drink two or more alcohol drinks per day?

No ☐ Yes ☐ Have you ever received treatment for abuse of alcohol or drugs? Explain

No ☐ Yes ☐ Do you often get depressed?

No ☐ Yes ☐ Have you ever received medical treatment for a "nervous breakdown"? Explain

No ☐ Yes ☐ Have you ever been under the care of a psychiatrist or psychologist? Explain

No ☐ Yes ☐ Do you have any other medical problems that have not been covered? Explain

No ☐ Yes ☐ Do you accept the fact that every medical and surgical treatment is associated with risks and Imponderables?

No ☐ Yes ☐ Do you have an Advanced Directive?

Signed _____ Date _____
(Patient)

Reviewed By: _____ Date _____
(Physician)

The information you have provided is essential in our comprehensive evaluation in your case.

Thank You,
ROUSSO FACIAL PLASTIC SURGERY CLINIC, P.C.

ROUSSO FACIAL PLASTIC SURGERY CLINIC

MEDICATION RECONCILIATION FORM

DISCONTINUED MEDICATIONS/PRODUCTS (DUE TO ALLERGIES, SIDE EFFECTS OR REACTIONS)

ALLERGIES – Medication/Food/Environmental	Side Effects, Reaction or Intolerance Experienced (Symptoms/Severity)

CURRENT MEDICATIONS (Include all Herbal Supplements, Vitamins & OTC)	DOSE	FREQUENCY	INDICATION (Reason for Taking)

NEW MEDICATIONS PRESCRIBED

DATE	Medication	Dosage	Given By

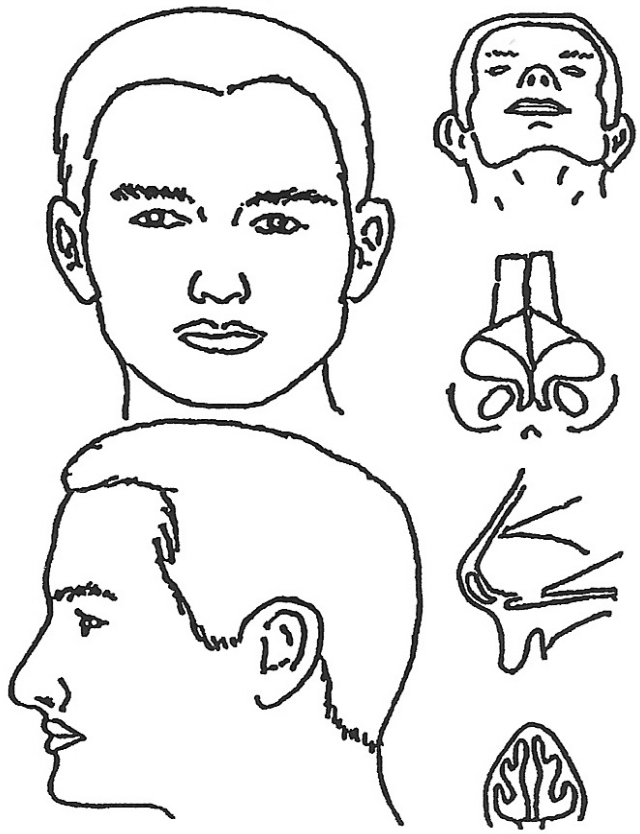
NAME	Date of Birth	Chart #	Reviewed By:	Date:
[redacted]				

Rousso Facial Plastic Surgery Clinic, P.C.
The Mountain Brook Center
2700 Highway 280 Suite 300 W
Birmingham, Alabama 35223

PATIENT WORKSHEET

(PATIENT INFORMATION)

Today's Date _____
Name _____
Address _____
City _____ **State** ____ **Zip** _____
Phone: Home _____
Business _____
Date of Birth _____ **Age** ____ **Sex (M) (F)**
Height _____ **Weight** _____
Social Security # _____
Insurance Carrier _____
Contract Number _____
Insured's Name on Card _____
Insured's Date of Birth _____
Person Responsible for Bill _____



(FOR OFFICE USE ONLY)

Date: _____

Examination, History, Photos, Procedure(s) & Recommendations:

ROUSSO FACIAL PLASTIC SURGERY CLINIC P.C.
Daniel E. Rousso, M.D.
2700 HWY 280, Suite 300-W
Birmingham, AL 35223

PATIENT CONSENT TO LEAVE PHONE MESSAGE/INFORMATION

Patient Name (print)_____

Dr. Daniel E. Rousso has adopted a policy that requires their staff to obtain authorization from the patient to leave detailed messages for the patient. This policy is to protect the patient and to also protect the employees of Rousso Facial Plastic Surgery Clinic from violating a patient's confidentiality. If an employee of Rousso Facial Plastic Surgery Clinic does not have a signed consent on file, the staff may only leave their first name with a brief message, e.g. "I am calling to remind you that you have a doctor appointment tomorrow at 9:00 AM".

By completing the consent below, you hereby authorize the staff to call and leave their name, the provider's name (Daniel E. Rousso, M.D.), and additional information on an answering machine, cell phone or at your place of work. Unless notified in writing, this consent will remain in effect permanently.

I give consent to Dr. Rousso and/or his staff to leave a message regarding appointments or other necessary information.

Please print phone numbers on line(s):

1._____On answering machine at home

2._____On cell phone voice mail

3._____On voicemail at work

4. _____Send you an email (**please write in email address if ok)**

_____ _____
Patient Signature **Date**

.....

I do NOT consent to <u>any</u> messages being left.

_____ _____
Patient Signature **Date**

05/2011

Rousso Facial Plastic Surgery
Aesthetic Medical Spa

HIPPA Notice of Privacy Practices

Acknowledgement of Receipt

I, _____, have received the Notice of Privacy form from Rousso Facial Plastic Surgery Clinic.

Date: _____

In lieu of patient signature, I , _____, a staff member of Rousso Facial Plastic Surgery Clinic, state that patient, _____, has been given our current Notice of Privacy Practices form.

Date:_____

ROUSSO FACIAL PLASTIC SURGERY
Patient Authorization for Payment and Authorization to Release Information

Authorization for Payment

I certify that the information provided by me is correct. I authorize my insurance company (ies) to furnish any agent of Rousso Facial Plastic Surgery any and all information pertaining to my insurance benefits and status of claims submitted by Rousso Facial Plastic Surgery. I authorize payment directly to Rousso Facial Plastic Surgery for Medicare benefits (as applicable) and other insurance benefits otherwise payable to me. In the event that my insurance carrier does not accept 'assignment of benefits', or any other payment are sent directly to me, I will hold them in trust for Rousso Facial Plastic Surgery for payment of my bill. I understand that I can make payment for service by either personal check or by endorsing the insurance payment by writing "Pay to the order of" Rousso Facial Plastic Surgery and my signature.

I understand that I am responsible to Rousso Facial Plastic Surgery for any/all charges not paid by a third party, including any co-payments, deductibles, or charges for non-covered services, except where program requirements or contractual agreements hold me harmless

Authorization to Release Information

I consent to the release of information and/or disclosure to Rousso Facial Plastic Surgery of all or any part of my medical record by any physician, hospital, or other facility of which I have been a patient; and release of information by Rousso Facial Plastic Surgery to individuals acting in official capacities as my advocate, representing governmental or third party payers, governmental agencies, accrediting bodies, or other health care providers involved in my care including any successors of Rousso Facial Plastic Surgery.

Signature: _____ Date: _____ Patient Name: _____
Patient or Authorized Representative Signature Applicable only if Authorized Representative signs for Patient

Signature: _____ Date: _____
Party Accepting Responsibility for Payment (on Patient's behalf) if applicable Relationship to Patient

Rousso Facial Plastic Surgery Representative (as witness): _____
Date: _____

For Translations:

This document was translated to patient/authorized representative into _____ language prior to signature and any questions were answered.

Translated By (Signature/Title): _____ Date: _____