CORRADO
CENTER FOR FACIAL PLASTIC & COSMETIC SURGERY

PATIENT INFORMATION

Name _____ Birth Date _____ Age _____
(First, Middle Initial, Last)

Address _____

City _____ State_____ Zip _____

Primary Phone _____ Secondary Phone _____

Email _____

Employer/School _____ Occupation _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Male ☐ Female

☐ Spouse or ☐ Parents Name _____

If patient is under 18 years of age: minor lives with ☐ both parents ☐ Mother ☐ Father

Mother's Phone _____ Father's Phone _____

EMERGENCY CONTACT

Name _____Phone _____ Relationship to patient _____

PHARMACY

Pharmacy _____ Phone _____

Address:_____

REASON FOR VISIT

SURGICAL PROCEDURES		NON-INVASIVE PROCEDURES
Blepharoplasty (Eyelid Lift)	Liposuction/SmartLipo	Botox
Chin Implant	Necklift	Filler
Facelift	Otoplasty (Ear Pinning)	Lip Augmentation
Facial Fat Grafting	Rhinoplasty	Liquid Facelift
Facial Reconstruction	Scar Revision	Liquid Rhino
Forehead/Browlift	Septoplasty (Deviated Septum)	VI "lunchtime" Peel
Laser Resurfacing	Split Earlobe Repair	Tear Trough

OTHER:_____

Is this your first consultation? ☐ NO ☐ YES **Ideal time frame for treatment:** _____

How did you hear about Dr. Corrado? _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Anthony Corrado, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. If the nature of the disability be such that it is not covered by insurance, I will be responsible to the doctor for payment of the entire bill. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission.

Patient/ Guardian Signature: _____ Date: _____

Name Printed: _____ If not patient, relationship: _____

NAME: _____

DOB: _____

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HEALTH INSURANCE

Primary Insurance Co. _____ Social Security # _____

Policy # _____ Group # _____

Name of person insured _____ Relationship to patient _____ Birth Date _____

Secondary Insurance Co. _____

Policy # _____ Group # _____

Name of person insured _____ Relationship to patient _____ Birth Date _____

PLEASE FILL OUT COMPLETELY – IF NOT APPLICABLE MARK N/A

Please list all:

Surgery or hospitalizations	**Diagnosis**	**Year**

Allergies

_____

_____

_____

_____

_____

Medications/Dosage/Frequency

_____

_____

_____

_____

FAMILY HISTORY

Medical Issue			**Family Member** (Father, Mother or other Relative)
Hypertension/High Blood Pressure	NO	YES	_____
Stroke	NO	YES	_____
Heart Attack	NO	YES	_____
Other Heart Disease*	NO	YES	_____
Osteoporosis	NO	YES	_____
Diabetes	NO	YES	_____
Caner	NO	YES	_____

Type of Cancer _____

*Please Explain _____

Other Disease _____

Other important Information _____

NAME: _____

DOB: _____

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SOCIAL HISTORY

Have you ever used tobacco products? ☐ NO ☐ YES If yes, how long? _____ How much? _____

Which tobacco product(s) have you used? _____

If you are a former smoker, state the year you stopped: _____

Past or current use of Nicotine Gum, Patch, or any other type of stop-smoking aid: ☐ NO ☐ YES If yes, please list: _____

Past or current substance abuse: ☐ NO ☐ YES If yes, please explain: _____

Alcohol Consumption ____ Never ____ Rare (1-2 drinks/wk) ____ Moderate (7-10 drinks/wk) ____ Heavy (daily/+10 drinks/wk)

Did you ever drink heavily in the past? ☐ NO ☐ YES

Are you feeling hopeless about the present/future? ☐ NO ☐ YES

Do you currently have thoughts of harming yourself? ☐ NO ☐ YES

PERSONAL HISTORY (Please check all that apply

CARDIOVASCULAR	
☐	High Blood Pressure
☐	Heart Attack
☐	Angina/Chest Pain
☐	Heart bypass surgery
☐	Pacemaker
☐	Heart Failure
☐	Irregular Heartbeat
☐	Heart Murmur
☐	
PSYCHIATRIC	
☐	Depression
☐	Anxiety
☐	Psychiatric Care
☐	Obsessive Compulsive Disorder
☐	
HEMATOLOGI/ONCOLOGIC	
☐	Bleeding Tendency
☐	Easy Bruising
☐	Anemia
☐	Sickle Cell Disease
☐	Blood clots in legs and/or lungs
☐	Radiation Therapy
☐	
ENDOCRINE	
☐	Diabetes
☐	Thyroid Disease
☐	Taken Steroids

RESPIRATORY	
☐	Abnormal Chest X-Ray
☐	Asthma
☐	Bronchitis
☐	Emphysema
☐	Recent Chest Infection
☐	Shortness of Breath at Night
☐	Shortness of breath on Exertion
☐	Cough
☐	Couth with Sputum
☐	Sleep Apnea
☐	Use a C-PAP Machine
☐	
SKIN	
☐	Basal Cell Skin Cancer
☐	Melanoma
☐	Staff Infection
☐	
URINARY	
☐	Kidney Disease
☐	Urinary Disease
☐	Dialysis
☐	
MUSCULOSKELETAL	
☐	Sciatica
☐	Herniated Disc
☐	Arthritis
☐	Rheumatoid

NEUROLOGICAL	
☐	Stroke
☐	Seizures
☐	Fainting
☐	Dizziness
☐	Headache
☐	Double Vision
☐	
INFECTIOUS GASTROINTESTINAL	
☐	Jaundice
☐	Hepatitis
☐	Ulcers
☐	Heartburn
☐	
EYES	
☐	Cataracts
☐	Glaucoma
☐	
FOR WOMEN	
Could you be pregnant? Y N	
Number of live births	
Number of pregnancies	
Date of last mammogram	
Date of last period	
WEIGHT: _____	
HEIGHT: _____	

Is there a personal OR family problems with anesthesia? ☐ **NO** ☐ **YES** Which type of anesthesia? ☐ **Local** ☐ **General**

If yes, please explain: _____

I attest that the health history as noted above is complete and accurate. All prescribed medicines and over the counter supplements and vitamins are listed. I understand that omissions or misrepresentations may affect my personal health, safety and/or the outcome of any procedure.

Signature: _____ Date: _____

NAME: _____

DOB: _____

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PHOTOGRAPHIC RELEASE

All patients must initial the following:

I HEREBY GIVE PERMISSION to Dr. Anthony Corrado and/or his Associate(s) or any assistant they may designate, to take photographs of me or my body parts in connection with the plastic surgery procedure(s) to be performed by Dr. Anthony Corrado and/or for diagnostic purposes.

I agree that these photographs will remain their property and a part of my permanent medical record. (Initial here :_____)

ADDITIONAL PHOTO USAGE –Patient may accept or decline the following:

I PROVIDE THIS AUTHORIZATION as a voluntary contribution in the interests of patient education. I understand that such photographs shall become the property of Dr. Anthony Corrado and may be retained by Dr. Anthony Corrado or released by Dr. Anthony Corrado for the limited purpose of including them in any print, visual, or electronic media, specifically including, but not limited to, publication in medical journals and textbooks, physician photo books, physician website, or for the purpose of informing the medical profession, the general public, or a patient about plastic surgery procedures and methods. **(Initial here :_____)**

I FURTHER AUTHORIZE them to use such photographs for teaching purposes. It is specifically understood that I shall not be identified by name. I understand that in some circumstances the photographs may portray features that will make my identity recognizable, even in instances where every effort is made to conceal my identity. **(Initial here :_____)**

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 **("HIPPA").**

I release and discharge Dr. Anthony Corrado and all parties acting under his license and authority from all rights that I may have to the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above authorization and release, and fully understand the terms.

_____
Patient Printed Name

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

NAME: _____

DOB: _____

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EMAIL CONSENT FORM

PATIENT NAME: _____PATIENT EMAIL: _____

PATIENT ADDRESS:_____

1. **RISK OF USING EMAIL**: Provider offers patients the opportunity to communicate by email. Transmitting patient information by email, however, has a number of risks that patients should consider before using email. These include, but are not limited to, the following risks:
   A. Email can be circulated, forwarded and stored in numerous paper and electronic files.
   B. Email can be immediately broadcast worldwide and be received by many intended and unintended recipients.
   C. Email senders can easily misaddress an email.
   D. Email is easier to falsify than handwritten or signed documents.
   E. Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
   F. Employers and online services have a right to archive and inspect emails transmitted through their systems.
   G. Email can be intercepted, altered, forwarded, or used without authorization or detection.
   H. Email can be used to introduce viruses into computer systems.
   I. Email can be used as evidence in court.
2. **CONDITIONS FOR THE USE OF EMAIL**: Provider will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of email communication and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of email for patient information. Consent for the use of email includes agreement with the following conditions:
   A. All emails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical cord, such as staff and billing personnel, will have access to those emails.
   B. Provider may forward emails internally to Provider's staff and agent necessary for diagnosis treatment, reimbursement and other handling. Provider will not, however, forward emails to independent third parties without the patient's prior written consent except as authorized or required by law.
   C. Although Provider will endeavor to read and respond promptly to an email from the patient, Provider cannot guarantee that any particular email will be read and responded to within any particular period of time. Thus, the patient shall not use email for medical emergencies or other time sensitive matters.
   D. If the patients email requires or invites a response from Provider, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.
   E. The patient should not use email for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
   F. The patient is responsible for informing Provider of any types of information the patient does not want to be sent by email, in additional to those set out in 2(e) above.
   G. The patient is responsible for protecting his/her password or other means of access to email. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
   H. Provider shall not engage in email communication that is unlawful, such as unlawfully practicing medicine across state lines.
   I. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.
3. **INSTRUCTIONS**: To communicate by email, the patient shall:
   A. Limit or avoid use of his/her employer's computer.
   B. Inform Provider of changes in his/her email address
   C. Put the patients name in the body of the email.
   D. Include the category of the communication in the emails subject line, for routing purposes (e.g., billing question).
   E. Review the email to make sure it is clear and that all relevant information if provided before sending to Provider.
   F. Inform Provider that the patient received an email from Provider.
   G. Take precautions to preserve the confidentiality of email, such as using screen savers and safeguarding his/her computer password.
   H. Withdraw consent only by email or written communication to Provider.
4. **PATIENT ACKNOWLEDGEMENT AND AGREEMENT**: I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between Provider and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by email. Any questions I may have had were answered.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

NAME: _____

DOB: _____

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NOTICE OF CONSULTATION FEE POLICY

Dear Patient:

The purpose of this document is to notify you of Dr. Anthony Corrado's consultation fee policy. Dr. Anthony Corrado charges a $100 fee for consultations, which include a medical examination to determine whether certain services or procedures would be appropriate for you.

At this time, you have scheduled your consultation with Dr. Corrado and paid the $100 consultation fee. We thank you for your interest in Dr. Corrado's services.

In the event that you are unable to meet Dr. Corrado at the scheduled time of your consultation and do not call Dr. Corrado's office to reschedule your consultation at least 48 hours in advance, or you do not show at the time of your consultation, your $100 fee will not be refunded. Under this policy, you are permitted to reschedule one (1) time provided that you give Dr. Corrado's office at least 24 hours advance notice of your need to reschedule.

Dr. Corrado and his staff would be happy to answer any questions you may have regarding this policy. Please direct any questions to our office at (877) 481-FACE.

Thank you.

NAME: _____

DOB: _____

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HIPAA – PATIENT CONSENT TO LEAVE MESSAGE

Dr. Anthony Corrado, LLC, in order to comply with the HIPAA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy fo the patient and to protect the physicians and staff of Dr. Anthony Corrado, LLC from violating the patient's confidentiality. If there is not a signed consent on file, physicians and staff will only leave their name and phone number on an answering machine, voicemail or with a live person answering the phone, requesting the patient to return the call.

By completing the consent below, you are allowing Dr. Anthony Corrado, LLC's physicians and its staff to leave a message on an answering machine, voicemail or with a specified individual. You may specify signing, you are also consenting to the mailing of facing of any results, requested by you, to your primary care physician or another physician involved in your care.

I give my consent to Dr. Anthony Corrado, LLC physicians and staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as necessary (check all that apply).

_____ on an answering machine or voicemail at home or cell phone

_____ on an answering machine or voicemail at work

_____ with _____ Relationship: _____

with _____ Relationship: _____

_____ I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly.

_____
Patient's Name (Please Print)

_____
Patient's Signature

_____
Witness

Notes:_____

HIPAA – NOTICE OF PRIVACY PRACTICE AGREEMENT

_____ I have been provided a copy of Dr. Anthony Corrado, LLC's Notice of Privacy Practice

_____ I have declined a copy of Dr. Anthony Corrado, LLC's Notice of Privacy Practice