Welcome to Givens Plastic Surgery

Date:_____ Ms.___Mrs.___Mr.___Dr.___ Name:_____
First MI Last

Date of Birth:_____ Age:_____ Gender: ☐ M ☐ F Social Security Number:_____

Home Address: _____

City, State, Zip: _____

Home Phone:_____ Cell Phone:_____ Email:_____
May we contact you at home? ☐ YES ☐ NO May we contact you on your cell? ☐ YES ☐ NO May we contact you on your email? ☐ YES ☐ NO

Occupation:_____ Employer:_____ Work Phone:_____
May we contact you at work? ☐ YES ☐ NO

Work Address:_____ City, State, Zip:_____

Emergency Contact: Name_____ **Relation**_____ **Phone Number**:_____
May we speak to him/her on your behalf? ☐ YES ☐ NO Special Notes/Additional Contact Information:_____

Procedure(s) of Interest (Check ALL that apply)

___ Austin Custom Lift
___ Brow Lift
___ Eyelid Lift
___ Lip Lift
___ Facial Liposuction
___ Fat Grafting
___ Facial Implants
___ Rhinoplasty
___ Revision Rhinoplasty
___ Chin Implant
___ Laser Resurfacing
___ Scar Revision
___ Earlobe Repair
___ PRP Hair Restoration
___ Blemish & Mole Removal
___ Facial Cancer Reconstruction
___ Botox & Dysport
Area(s):_____
Botox Facial ☐ YES
___ Filler Refinement
Area(s):_____

How did you hear about us? Please provide name of referral source so that we may thank him/her.

☐ Givens Facial Plastic Surgery Website
☐ Doctor Referral _____
☐ Friend/Family _____
☐ Other:_____
☐ Social Media Platform
☐ Instagram ☐ Facebook ☐ IGTV ☐ YouTube
☐ Physician Review Source
☐ Google ☐ Real Self ☐ Health Grades

Patient Authorization & Consent

- I am at least 18 years of age or accompanied by an adult. I consent to examination or treatment by Dr. Givens and her staff.
- I understand that I am responsible for my insurance co-pay and deductibles on the day of my visit and am obligated to notify the practice immediately of any changes to my coverage.
- I authorize Dr. Givens or her designated staff member to access my Health Records.

Patient/Guardian Signature:_____ **Date:**_____ **Staff Initials:**_____

MEDICAL & SURGICAL HISTORY
Victoria B Givens, MD

Age:_____ Gender: ☐ M ☐ F Ethnicity:_____ Height:_____ Weight:_____ Other:_____

Please select any of the following medical conditions you have or have had in the past. ☐ NONE

- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Heart Disease/CAD
- ☐ Heart Murmur
- ☐ Chest Pain/Angina
- ☐ Heart Attack—year:____
- ☐ Pre-diabetes: A1C____
- ☐ Diabetes: A1C____
- ☐ Hypoglycemia
- ☐ Chronic Cough
- ☐ Asthma
- ☐ Lung Disease_____
- ☐ DVT/PE—year_____
  - ☐ IVC Filter—year:_____
- ☐ Reflux/Heart Burn
- ☐ Stomach Ulcers
  - ☐ Ulcer Bleeds—year:_____
- ☐ Excessive Scarring/Keloids
- ☐ Lupus
- ☐ Scleroderma
- ☐ Cancer:_____
  - ☐ Chemotherapy_____
  - ☐ Radiation_____
- ☐ Immunosuppressive Drugs
- ☐ Anemia
- ☐ Blood Transfusions
- ☐ HIV/AIDS
- ☐ Hepatitis:_____
- ☐ Clotting Disorder_____
- ☐ Kidney Disease
- ☐ Staph Infections/MRSA
- ☐ Cold Sores/Fever Blisters
- ☐ Skin Condition/Shingles
- ☐ Drug Dependency
- ☐ Alcohol Addiction
- ☐ Epilepsy/Convulsions
- ☐ Anxiety ☐ Depression
- ☐ Bipolar ☐ Schizophrenia
- ☐ Eating Disorder
- ☐ Other Psychiatric Dx
  - ☐_____
- ☐ Migraines ☐ TMJ
- ☐ Sleep Apnea
- ☐ Glaucoma
- ☐ Dry Eye Syndrome
- ☐ Thyroid Disorder
- ☐ Myasthenia Gravis
- ☐ Raynaud's Syndrome

List any medical conditions that have NOT been covered and/or additional information that you believe would be important for us to know. _____

Medical Questionnaire

1. **Are you pregnant? ☐ YES ☐ NO Date of Last Menstrual Cycle:_____**

2. **Do you smoke? ☐ YES ☐ NO # of packs/day:_____ If stopped, when?_____**

3. **Does anyone in your household smoke? ☐ YES ☐ NO**

4. **Do you use a nicotine patch/substitute or other tobacco product (ie, dip)? ☐ YES ☐ NO**
   If yes, which product(s)?_____

5. **Do you use any inhalational products (ie, vaping, E-cig, THC/Marijuana)? ☐ YES ☐ NO**
   If yes, which product(s)?_____

6. **Do you drink or take caffeine? ☐ YES ☐ NO Do you drink alcohol? ☐ YES ☐ NO**
   If yes, # of caffeinated drinks/day:_____ If yes, # of Alcohol drinks/day:_____

7. **Have you ever taken Accutane? ☐ YES ☐ NO If stopped, when?**_____

8. **Have you ever had a coronary stent placed? ☐ YES ☐ NO Physician Name:**_____

9. **Eye History**
   - **Do you require: ☐ Glasses ☐ Contacts Date of Last Eye Exam:**_____
   - **Do you have or ever had any visual problems and/or injuries to your eyes or eyelids? ☐ YES ☐ NO**
     Explain:_____
   - **Have you had any surgery to your eyes or eyelids? ☐ YES ☐ NO** ***(please list under surgery section on next page)***
   - **Do you have any of the following symptoms associated with your eyes or eyelids? ☐ NONE**
     ☐ Excessive Swelling ☐ Frequent Allergies/Irritations ☐ Dry Eyes ☐ Watery Eyes ☐ Spontaneous Tearing
   - **Do you use eye drops? ☐ YES ☐ NO If yes, how often?**_____

10. **Do you have any of the following? ☐ NONE**
    ☐ Loose or Chipped Teeth ☐ Caps ☐ Veneers ☐ Dental Implants ☐ Dentures ☐ History of dental infections

Physician Resources

1. Primary Care Physician:_____ Phone Number:_____
2. Cardiologist: _____ Phone Number:_____
3. Other: _____ Phone Number:_____

MEDICAL & SURGICAL HISTORY

Victoria B Givens, MD

List *all* surgeries including date of surgery (ie, year) you have had below. ☐ NONE

_____

_____

_____

Have you ever had any reaction (nausea, etc) to local or general anesthesia? ☐ YES ☐ NO

If yes, please describe: _____

Do you have a personal or family history of malignant hyperthermia? ☐ YES ☐ NO

List *all* medications you are currently taking or have taken in the past 6 months below. ☐ NONE

MEDICATION	DOSAGE	FREQUENCY	**Include *any* of the following:**
			Birth Control Pills and Devices, Blood Pressure (lisinopril, HCTZ, losartan, norvasc, diuretics), Blood Thinners (aspirin, coumadin, warfarin), Diet Pills, Cardiac (digoxin, metoprolol, nitroglycerin), Glaucoma Drops, Diabetic (metformin, insulin), Asthma Medications, Sleeping Aids, Anti-Depressants, Pain Pills/Shots, Epilepsy Medications, Steroids

Do you take any of the following vitamins or herbal/nutritional supplements?

☐ Vitamin E ☐ Fish Oils/Omega-3s ☐ Glucosamine ☐ Gingko Biloba ☐ St. John's Wart

☐ Protein Powder ☐ Garlic Supplement ☐ Turmeric/Curcumin Supplement

**These medications must be stopped 2 weeks before and after surgery as they increase one's risk of bleeding.*

List *all* known allergies, as well as reactions, even to materials below. ☐ NONE

ALLERGIES	REACTIONS	**Include *any* of the following:**
		Latex, Elastic, Tape, Adhesives

Preferred Pharmacy for Medications

Pharmacy Name: _____

Address: _____

Phone Number: _____

Confidential Record: *Information contained here will NOT be released unless you have authorized us to do so. All questions should be answered to the best of your knowledge. The information provided by you will be used by Dr. Givens in making decisions regarding your care.*

- I authorize Dr. Givens and her staff to telephone or otherwise contact me (or responsible party) regarding appointments, treatment information, and/or any other details related to patient therapy and treatment.

Patient/Guardian Signature: _____ **Date:** _____ **Staff Initials:** _____

GIVENS
FACIAL PLASTIC SURGERY

At Givens Facial Plastic Surgery, we provide consultations for elective, cosmetic procedures as well as procedures that will involve full or partial coverage by medical insurance. We accept insurance for procedures to treat facial trauma, skin cancer, forehead and eyelid related visual impairment, and nasal obstruction. To determine whether insurance will cover the procedure(s) that you require, a physician visit will be conducted by Dr. Givens and billed to your insurance company. Your co-payment or co-insurance will also be collected upon check-out following your visit.

It is our pleasure to try to obtain pre-authorization from your insurance carrier for specific procedures. In many cases, we are able to confirm that a procedure is covered by your insurance carrier. However, all out-of-pocket and co-insurance fees associated with your procedure must be determined between you and your insurance carrier. Insurance deductibles which have not been met require payment prior to your surgery. If this form is incomplete, you will be billed directly.

If your insurance requires that you have a referral from your Primary Care Physician (PCP), you must hand this by calling your PCP. Please check to be sure that Dr. Givens is contracted with your insurance company. Some PCP's may refer you to a physician that is not contracted with your insurance company, which poses a problem for you. If we are not a network provider for you, then check to see if you have out-of-network benefits. If so, out-of-network coverage is provided at a reduced rate. Refer to the phone number on your insurance card.

In order for our facility to give you the most information regarding your insurance benefits, you must supply us with a CURRENT insurance card including the billing address and phone number. Our office staff can help you with any questions you may have if you call during our regular business hours. Thank you for taking the time to fully understand our insurance policy. Your clear understanding of these policies is important to our professional relationship.

PRIMARY INSURANCE INFORMAITON

Primary Insurance: _____

Address to Mail Claims: _____

Phone: _____

ID#: _____ **Group#:** _____ **Claim#:** _____

Cardholder's Name: _____ **DOB:** _____ **SSN:** _____

Cardholder's Address: _____

Employer: _____

SECONDARY INSURANCE INFORMAITON

Secondary Insurance: _____

Address to Mail Claims: _____

Phone: _____

ID#: _____ **Group#:** _____ **Claim#:** _____

Cardholder's Name: _____ **DOB:** _____ **SSN:** _____

Cardholder's Address: _____

Employer: _____

Patient Acceptance of Financial Responsibility

- I certify that I understand and agree to the insurance policy outlined above. I recognize and accept full financial responsibility for all professional services rendered, regardless of the amounts covered by any applicable insurance coverage.
- In the event Givens Facial Plastic Surgery is required to collect my account after default, I will be responsible for all attorney fees and cost of collection.
- If insurance is to be filed, I authorize release of my medical information including photographs necessary to process any claim for services provided by Givens Facial Plastic Surgery.
- I further authorize an insurance company to pay benefits directly to Givens Facial Plastic Surgery.

Patient/Guardian Signature: _____ **Date:** _____ **Staff Initials:** _____

NOTICE OF PRIVACY PRACTICE

This is a notice that Givens Facial Plastic Surgery, PLLC participates with the privacy practice Health Insurance Portability and Accountability Act (HIPAA) regulations. It is our intent to protect our patients' confidentiality within all reasonable means.

The HIPAA regulations are meant to protect your personal health information. However, the practice encounters patients who appoint others to call the office to arrange appointments and take care of financial aspects of their care.

Please indicate below if there are any persons whom you may provide the practice authorization to release information regarding your appointments, medical, and/or financial information.

Name	Relationship	All Appointments Medical Financial (Please circle any that may apply)
Name	Relationship	All Appointments Medical Financial (Please circle any that may apply)
Name	Relationship	All Appointments Medical Financial (Please circle any that may apply)

I hearby acknowledge that I have been made aware of the Notice of Privacy Practices from Givens Facial Plastic Surgery, which sets forth the ways in which my personal health information may be used or disclosed by Givens Facial Plastic Surgery and outlines my rights with respect to such information. I understand that I may read a copy of it by my request.

Please indicate if you would like a copy of our HIPAA policy. ☐ YES ☐ NO If yes, provide best email:_____

I authorize the release of any information acquired in the course of my examination or treatment if necessary to determine benefits.

Patient/Guardian Signature:_____ **Date:**_____ **Staff Initials:**_____