ROBB FACIAL PLASTIC SURGERY
& MEDICAL SPA
3400 OLD MILTON PKWY
BUILDING C, SUITE 570
ALPHARETTA, GA 30005

Name:_____DOB:_____ Sex:M / F

Address_____

City:_____ State_____ Zip_____

Cell #_____Home #_____Work #_____

Which phone number(s) may we use to leave messages? _____

E-mail address_____ Religion preference_____

Occupation_____ Employer _____

Emergency Contact _____ Phone # _____

How did you hear about our practice?_____

May we thank them for the referral? Y / N

Which services are you interested in? (Please check all that apply.)

_____**Browlift/Eyelid Surgery**
_____**Face/Necklift, Midface Lift**
_____**Restylane/Radiesse/Botox**
_____**Implants (Mid-face, Chin, Lip)**
_____**Botox®Dysport(Neuromodulators)**
_____**MicroLaser Peel**
_____**Laser Skin Resurfacing**
_____**Buccal Fat Removal**
_____**Rhinoplasty**
_____**Laser Hair Removal**
_____**Dimple Creation**
_____**Lip Augmentation**
_____**Scar Revision**
_____**Otoplasty**
_____**Other**

Medications- Please list all medications that you are currently taking. **(Include diet pills, herbal preparations, over-the counter medications and vitamins**)

Name of Drug	Strength/Dosage	Condition Treated

Allergies-Please list all allergies or sensitivities to medications, tapes, or antiseptic cleansers. If no allergies, please indicate none.

_____

_____

Name and city of your personal physician: _____

Pharmacy Name and Phone Number: _____

MEDICAL ISSUES:

YES NO

☐ ☐ GENERAL- Do you have diabetes or high blood pressure?

☐ ☐ HEART- Have you had heart trouble, heart attack, angina, chest pain, arrhythmias, arteriosclerosis, rheumatic heart disease, damaged or artificial heart valves, heart murmur, or aneurysm?

☐ ☐ LUNGS- Do you have asthma, lung disease, shortness of breath, bronchitis, emphysema, or tuberculosis?

☐ ☐ GI- Have you had a hernia, stomach ulcer, hyperacidity, irritable bowel, or chronic constipation or diarrhea?

☐ ☐ LIVER- Do you have liver disease, hepatitis, jaundice, or alcoholism?

☐ ☐ KIDNEY- Do you have a history of kidney stones, urinary tract infections, kidney disease, or dialysis?

☐ ☐ BRAIN- Have you had a stroke, fainting spells, seizures, migraines, depression, anxiety, or psychiatric issue?

☐ ☐ ENDOCRINE- Do you have thyroid problems, Cushing's disease, or other endocrine problems?

☐ ☐ BLOOD- Have you had any blood disorders, blood clots, anemia, abnormal bleeding, blood transfusions?

☐ ☐ AUTOIMMUNE- Do you have an autoimmune disease, "collagen disease" (eg, Lupus, Rheumatoid Arthritis, Raynaud's disease), or any persistent swollen neck glands or lymph nodes?

☐ ☐ CANCER- Do you have any history of cancer, growth, tumor, or history of radiation or chemotherapy?

☐ ☐ INFECTION- Do you have any history of cold sores, tuberculosis, HIV, Hepatitis C, or MRSA infection?

☐ ☐ HEALING- Do you have any history of steroid use, keloid scarring or poor wound healing?

☐ ☐ Have you ever had a problem with general anesthesia?

☐ ☐ Have you had any changes in your health in the past year? If so, please explain:

_____

If you answered "YES" to any of these questions, please explain:

_____

_____

_____

Fitzpatrick Skin Test: Please **circle** the one that describes your skin type.

Type I: Always burns, never tans. Red or blond hair, light eyes. (**Nicole Kidman or Prince Harry)**
Type II: Somewhat tans, mostly burns. (**Jennifer Aniston or Brad Pitt**)
Type III: Sometimes burns, mostly tans. **(Sandra Bullock or Matthew McConaughey**)
Type IV: Rarely burns, most always tans, also known as "olive" complexion. (**Jessica Alba or Derek Jeter**)
Type V: Moderately pigmented (**Indian, Hispanic, etc**.)
Type VI: African American (**Oprah or Seal**)

What is your current skin care routine?

_____
_____
_____
_____

Circle any of the following that you are currently using or have used?

Retinol	Glycolic Acid	Topical Steroids
Salicylic Acid	Citric Acid	Lactic Acid
Adapalene (Differin)	Hydroquinone	Resorcinol
Topical Antibiotics	Azelaic Acid (Azelex, Finacea)	

Are you currently using Retin-A, Renova, or Differin? ____ Yes ____ No
If so, how long?____ less than 3 mos.____3 mos.-1 year____1 year

Are you currently using the drug Accutane? ____ Yes ____No ____Taken in past

Have you ever had any of the following? (circle)

Botox Microdermabrasion Restylane Radiesse Fat transfer

Have you ever had laser treatment? ____ Yes ____ No

Have you had any cosmetic peels? ____ Yes ____No
If so, ____ Spa facial ____ Glycolic/Salicylic/Lactic Acid ____ TCA/Blue Peel, _____Other

Have you ever been treated for any psychiatric/emotional problems?
____Depression ____Anxiety _____ Other
_____

Medical Questionnaire
Do you smoke?_____ If yes, how much?_____

Do you drink alcoholic beverages?_____ If yes, how often? Socially Daily

Do you take any recreational drugs?_____ If yes, please specify._____

Medical History
Are you presently under the care of a physician for any medical condition? Y N
If yes, please explain._____

Are you pregnant? _____Planning _____ Yes _____ No
Breast feeding? _____ Yes _____ No

Surgical History- *Please list all previous surgeries, and dates (including cosmetic).*
_____ _____
_____ _____
_____ _____

Hospitalizations- *Please list reason and dates.*
_____
_____
_____

Family History-*Please indicate if any immediate family member has ever had any of the following:*
_____ Heart Disease _____ Autoimmune Disorders
_____ Anesthetic Complications _____ Other
_____ Bleeding Disorder

Patient Signature _____*Date*_____

Physician Signature _____*Date*_____

ROBB
FACIAL PLASTIC &
RECONSTRUCTIVE SURGERY

Video/Audio/Photo Release Form

I understand the photograph(s) or video or audio recording(s) taken of me by staff, agents, employees, or representatives of Robb Facial Plastic Surgery shall be used for education and promotional purposes, including without limitation, advertising and social media, and evaluation of medical procedures and sharing of that information with primarily, but not limited to, patients, physicians, surgeons, and others.

I hereby authorize Robb Facial Plastic Surgery to copy, exhibit, publish or distribute any and all such images and audio of me or wherein I appear, including composite or artistic forms and media, for purposes of publicizing Robb Facial Plastic Surgery or Dr. Robb Jr. or for any other lawful purpose.

I hereby hold harmless and release and forever discharge Robb Facial Plastic Surgery and Dr. Robb Jr. from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

This authorization is voluntary. I understand that the Practice cannot condition treatment of the Patient on whether I sign this Authorization, and that my decision not to sign will not influence or affect the Patient's treatment in any way.

_____ With no identifying factors (We will blur certain areas or Cover certain parts of the face to keep identity private)

_____ You can show my entire face

Signature: _____

Print Name: _____Date: _____

Notice of Privacy Practices

3400 Old Milton Parkway
Building C, Suite 570
Alpharetta, GA 30005
Ph: (470) 336-1850
info@robbfacialplastics.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

ROBB FACIAL PLASTIC SURGERY has developed the following privacy policies.

Uses and Disclosures

Treatment- Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all health professionals who may provide treatment or who may be consulted by staff members.

Payment- Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations- Your health information may be used as necessary to support the day-to-day activities and management of ROBB FACIAL PLASTIC SURGERY. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement- Your health information may be disclosed to law enforcement agencies without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandate reporting.

Public Health Reporting- Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures Require Your Authorization- Disclosure of your health information or its use for any purpose other than those listed above require your specific written authorization. If you change your mind after authorizing a use of disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision.

Practice Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Rights to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next visit. The revised policies and practices will be applied to all protected health information that we maintain.

Authorization for Phone Calls

I authorize the staff of Dr. Philip K. Robb Jr. to call my home or work phone number regarding office appointments and/or surgery information.

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I authorize the staff of Dr. Philip K. Robb Jr. to leave a message on my voicemail or telephone recorder regarding office appointments and/or surgery information.

Complaints/Contact Person

If you would like to submit a comment or complaint about our privacy practices, or if you believe that your privacy rights have been violated; you should call the matter to our attention by sending a letter outlining your concerns to:

Robb Facial Plastic Surgery
3400 Old Milton Parkway
Building C, Suite 570
Alpharetta, GA 30005

You will not be penalized or otherwise retaliated against for filing a complaint.

Expiration Date of Authorization

This authorization is valid for five (5) years from the date of signature unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate of Revoke Authorization

You may revoke or terminate this authorization by submitting written revocation to ROBB FACIAL PLASTIC SURGERY. You should contact the practice manager to terminate this authorization.

Acknowledgement Form

I acknowledge receipt of this Notice of Privacy Rights, which I have reviewed and given my permission to ROBB FACIAL PLASTIC SURGERY to use and disclose my health information in accordance with it.

_____ _____

Patient's Signature Date

_____ _____

Patient's Name Date

Notice of Privacy Practices

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Alpharetta, GA 30005
Ph: (470) 336-1850
info@robbfacialplastics.com

Robb Facial Plastic Surgery Plastic & Reconstructive Surgery Center 3400 Old Milton Parkway, Bldg C Ste 570 Alpharetta, GA 30005 (470) 336-1850

COMMUNICATION BY EMAIL/ TEXT

Security Risks

Most standard email providers such as Gmail, Yahoo, Hotmail, etc. and most cellular providers do not provide a secured or encrypted means of communication. As a result, there is risk that any protected health information contained in an email or text message may be disclosed to, or intercepted by, unauthorized third parties. Additionally, email and text messages accessible through personal computers, laptops, or phones have inherent privacy risks especially when the email or cellular account is provided by an employer, when the account is not password protected, or the account is shared. Use of more secure communications, such as phone, fax, or mail is preferred and always an available alternative.

Responsibility

When consenting to the use of email or text through such unsecured or unencrypted systems, you are accepting responsibility for any unauthorized access or disclosure to protected health information contained within the message. The Practice will not be responsible for unauthorized access of protected health information while in transmission and will not be responsible for safeguarding information once it is delivered. The Practice will take steps to ensure that any email or text message with protected health information is protected prior to being sent to the requested address and will use the minimum necessary amount of protected health information when communicating with you.

Additional Information

It is important to understand that emails and text messages will not be used to replace or facilitate communications between you and your physician and will not be considered private communications. There is no guarantee that the Practice will be actively monitoring emails and text messages, so responses and replies sent to or received by you or the Practice may be hours or days apart. Email and text messages may be inadvertently missed or errors in transmissions may occur. The Practice will not be responsible for any issues caused by delays in communications. If you have an immediate need or an emergency situation, you must contact the Practice by telephone or dial 9-1-1 if applicable. Practice staff will be utilized to monitor the inbox in order to properly direct or respond to communications received. Therefore, any information considered sensitive should not be included in your communications. At the Practice's discretion, any email or text message received or sent may become part of your medical record.

By completing and signing this form, or by initiating contact with the Practice via email, text, or web form, I am accepting that Robb Facial Plastic Surgery may communicate with me via email or text message via the provided contact information and acknowledge the inherent limitations therein.

Print Name: _____

Signature: _____ Date: _____

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Alpharetta, GA 30005
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