PATIENT INFORMATION FORM

Today's Date: _____

Name: _____ **DOB:** _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Please only provide us phone numbers we are allowed to use to reach you.

By giving us contact number(s) you authorize us to contact you -including leaving a message, sending text messages, sending emails, and/or conducting telehealth or virtual consultations.

Mark your preferred primary method of contact below.

☐ **Cell**	☐ **Home**	☐ **Work**	☐ **Email**	☐ **Regular Mail**

Home Phone: _____ **Work:** _____ **Cell:** _____

Cell Carrier*: ☐ **AT&T** ☐ **Verizon** ☐ **T-Mobile** ☐ **Sprint** ☐ **Other:** _____

*This is needed so we can text you.

Email: _____

Would you like to receive monthly specials & announcements?
☐ Yes ☐ No

Who can we thank for introducing you to our practice?

☐ Physician Referral:

_____

☐ Friend/Relative/Current Patient:

_____

☐ Web Search Search Term: _____

☐ Practice Website (DrGoldman.com) ☐ Facebook ☐ Instagram

☐ Other: _____

Emergency Contact(s): Please list at least one emergency contact that you give us permission to discuss your care.

Name: _____ Relationship: _____ Phone: _____

Pharmacy Name and Phone Number:

Preferred Pharmacy: _____ City:_____ Phone: _____

Primary reason for appointment:

_____

Would you like a complimentary skin care consultation with one of our licenced medical aestheticians? ☐ Yes ☐ No

Section I: Personal Medical History

Are you pregnant or nursing? ☐ No ☐ Yes Height: _____ Weight: _____

Date of last mammogram? _____ Are you under the care of a physician (other than OB/PCP)? ☐ No ☐ Yes

If YES, list what for: _____

Please list all surgeries you have had (including wisdom teeth, c-sections, cosmetic procedures etc.): _____

_____

Please list all current medications (including over the counter &/or vitamin and herbal supplements): None ☐

_____

Do you have any allergies to medications? ☐ No ☐ Yes Please list all & type of reaction: _____

_____

Do you have any of the following specific allergies? None ☐

Lidocaine/Novocain? ☐ No ☐ Yes: Reaction _____

Shellfish? ☐ No ☐ Yes: Reaction _____

Eggs? ☐ No ☐ Yes: Reaction _____

IV Contrast Dye? ☐ No ☐ Yes: Reaction _____

Sodium Metabisulfite or Sulfites (found in foods & RX preservatives)? ☐ No ☐ Yes:
Reaction _____

Section II: Specific Medical History

Have **you** or do you still have:	**No**	**Yes**		**No**	**Yes**
Asthma	☐	☐	Anesthesia Complications	☐	☐
Lung Disease (including COPD or Emphysema)	☐	☐	Blood Clotting/Bleeding Abnormalities	☐	☐
High Blood Pressure / Hypertension	☐	☐	Severe Allergies	☐	☐
Heart Disease	☐	☐	Repeated Infections	☐	☐
Liver Trouble including Hepatitis	☐	☐	Arthritis	☐	☐
Kidney Trouble	☐	☐	Cancer	☐	☐
Thyroid Imbalance	☐	☐	Problem Scarring (Keloids)	☐	☐
Diabetes	☐	☐	Migraines	☐	☐
Epilepsy or Seizures	☐	☐	Rosacea	☐	☐
Stroke	☐	☐	Frequent Cold Sores	☐	☐
Psychiatric Care (Please include Depression, OCD, Anxiety or Eating Disorders)				☐	☐
Others not listed: _____				☐	☐

Section III: Social History

Currently Smoke? ☐ No ☐ Yes, how much/often? _____

Former Smoker? ☐ No ☐ Yes, quit date? _____

Do you drink alcohol? ☐ No ☐ Yes, how much/often? _____

Do you exercise regularly? ☐ No ☐ Yes, how much/often? _____

Do you have any children? ☐ No ☐ Yes, how many? _____

Section IV: Family Medical History

Any of your close family members (mother, father, sibling, grandparents, or children) have any of the following? None ☐

Bleeding or Clotting Disorders: ☐ No ☐ Yes, Who? _____

Anesthesia Complications: ☐ No ☐ Yes, Who? _____

Cancer: ☐ No ☐ Yes, Who? _____

Problems Scarring (Keloids): ☐ No ☐ Yes, Who? _____

I certify that I have read this questionnaire and disclosed my medical history to the best of my knowledge:

Signature: _____ Date: _____

HIPAA Information and Consent

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office and available in our lobby.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, texting, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. As of March 17, 2020 US Health and Human Services authorized doctors to use non-public facing audio and/or video communication technology to provide telehealth. Even authorized non-public facing third-party applications potentially introduce privacy risks, however we will enable all available encryption and privacy modes when using these applications.
4. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
5. You understand and agree to inspections of the office and review of documents which may include PHI by government and oversight agencies or insurance payers in normal performance of their duties.
6. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
7. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
8. We agree to provide patients with access to their records in accordance with state and federal laws.
9. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
10. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes of office policy. I further release my doctor and all parties acting under my doctor's license and authority form any telehealth medical privacy claims I may have had prior to HHS's March 17th, 2020 notification. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

Photo Consent

Before & After photographs are important proofs as to the success of your treatments.
We fully realize the sensitive nature of these images and keep your identity protected at all times.

I, _____, hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery &/or treatments. The photographs will be taken by one of the members of Dr. Goldman's medical staff. I hereby give consent that Beachwood - Westlake Plastic Surgery & Medical Spa can photograph or film me but only to the extent necessary, and so long as the images are used solely for purposes of (a) identifying me as a patient or for purposes of diagnosis and treatment and documenting my health status; (b) conducting education and training, quality assurance and performance improvement functions for and on behalf of Dr. Goldman and his professional staff.

I, _____, do hereby consent and acknowledge my agreement to be photographed as listed above.

Signature: _____ Date: _____