# STEIN PLASTIC SURGERY

## Patient Intake Sheet

(Please Print Legibly & Fill In or Correct All Fields)

**Patient's Name** _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____
(We will never share your e-mail with any other entity)

Contact Restrictions: _____

Age _____ Birthdate _____ Driver's License #/State _____ ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

**Patient's Employer** _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

**Emergency Contact**
(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Cell Phone _____ Work Phone _____

**Areas that may interest you:***

- ❒ Blepharoplasty (Eyelid Lift)
- ❒ Brow/Forehead Lift
- ❒ Facial Implants (Cheek/Chin)
- ❒ Facial Liposuction (Neck, Jowls)
- ❒ Face or Neck Lift
- ❒ Lip Enhancement
- ❒ Otoplasty (Ear Pinning)
- ❒ Rhinoplasty (Nose Reshaping, Septoplasty)
- ❒ Skin Resurfacing (Laser, Chemical Peel)
- ❒ Toxins/Fillers (injections)

**How did you hear about Dr. Stein?**

Website: _____ Search Engine: _____

Social Media: _____ Magazine: _____

Friend/Relative: _____ Doctor: _____

If you were referred by a specific person, may we thank them? ❒ Yes ❒ No

Pursuant to HIPAA, I acknowledge and agree that I have been provided a copy of the Stein Plastic Surgery Notice of Privacy Practices that describes how my protected health information must be protected and my rights to access and control such information. I acknowledge and agree that I have been able to review the Notice of Privacy Practices in its entirety and been given the opportunity to ask any questions regarding the use or disclosure of my protected health information and my associated rights. I acknowldge and agree that I have had all my questions answered to my satisfaction. I understand that a copy for my keeping is available at anytime upon my request.

Signature: _____ Date: _____

# Stein Plastic Surgery

## Health Information

(Please Print Legibly & Fill In or Correct All Fields)

DO YOU NOW OR HAVE YOU EVER HAD……. (Please Circle an Answer for Each Item)

| | | |
|---|---|---|
| Blood Pressure Abnormalites | Yes | No |
| Hypertension | Yes | No |
| Chest Pain | Yes | No |
| Palpitation or Irregular Pulse | Yes | No |
| Heart Murmur | Yes | No |
| Abnormal EKG | Yes | No |
| Heart Trouble | Yes | No |
| Heart Attack | Yes | No |
| Stroke | Yes | No |
| Family History of Cancer/Heart trouble/Stroke | Yes | No |
| Shortness of Breath | Yes | No |
| Asthma | Yes | No |
| Pneumonia | Yes | No |
| Smokers Cough | Yes | No |
| Emphysema | Yes | No |
| Coughing or Spitting of Blood | Yes | No |
| Tuberculosis | Yes | No |
| Airway Obstruction (Nasal) | Yes | No |
| Esophageal Varices | Yes | No |
| Cold Sores / Fever Blisters | Yes | No |
| Glaucoma or Eye Problems | Yes | No |
| Visual Disturbances | Yes | No |
| Loss of Vision | Yes | No |
| Acutane Treatment for your Skin | Yes | No |
| Unsightly Scars | Yes | No |
| Keloids | Yes | No |
| Skin Disorders | Yes | No |
| Seizures, Convulsions or Fainting Spells | Yes | No |
| Black outs | Yes | No |

| | | |
|---|---|---|
| Any Part of your Body Been Paralyzed | Yes | No |
| Palsy | Yes | No |
| Breast Cysts, Tumors, Abscesses | Yes | No |
| Nipple Discharge (excluding Normal Lactation) | Yes | No |
| Thyroid Problems | Yes | No |
| Chemotherapy or Radiation Treatments | Yes | No |
| Missed or Irregular Menstrual Period | Yes | No |
| Bruise or Bleed Easily | Yes | No |
| Bleeding Problems or Disorder | Yes | No |
| Any Family with Bleeding Problems/Disorder | Yes | No |
| Ulcers | Yes | No |
| Kidney or Renal Disease | Yes | No |
| Cirrhosis of the Liver | Yes | No |
| Hepatitis | Yes | No |
| Exposure to HIV, AIDS, Hepatitis | Yes | No |
| Positive Blood Test for: HIV, AIDS, Hepatitis | Yes | No |
| Autoimmune Disorder / Disease | Yes | No |
| Diabetes | Yes | No |
| Arthritis | Yes | No |
| Are you Easily Upset or Irritated | Yes | No |
| Do you Often Feel Unhappy or Get Depressed | Yes | No |
| Psychiatric Hospitalization or Care | Yes | No |
| Alcoholism or Drug Use / Dependency | Yes | No |
| Drug Allergy | Yes | No |
| Food Allergy | Yes | No |
| Allergic to Latex or Latex Products | Yes | No |
| Local Anesthesia by Dentist/Doctor | Yes | No |
| Local Anesthesia Difficulty/Reaction/Problem | Yes | No |
| Family History of Anesthesia Problems | Yes | No |

If you answered “yes” to any of these questions, please explain here:

_____

_____

_____

Please list all present medications. Include all over-the-counter medications.
(Include birth control pills, hormones, vitamins, herbal supplements, diuretics, weight loss drugs, etc.)

_____

_____

_____

_____

_____

Signature: _____ Date: _____

## Health Information (continued)

(Please Print Legibly & Fill In or Correct All Fields)

Do you have an allergic reaction to any medication? ❒ Yes ❒ No Which? _____

Do you react abnormally to any medication? ❒ Yes ❒ No Which? _____

Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?
❒ Yes ❒ No If yes, when and where? _____

Have you ever been on cortisone or steroid treatment? ❒ Yes ❒ No When? _____

Do you have cocktails regularly, or consume regular amounts of alcohol, including beer, wine, or other alcohol?
❒ Yes ❒ No If so, how much? _____

Do you smoke? ❒ Yes ❒ No If so, how much? _____ For how long? _____

Are you pregnant? ❒ Yes ❒ No When was you last normal menstrual period? _____

How many pregnancies? _____ Births? _____ Breast Fed? ❒ Yes ❒ No How long? _____

Children (list names and ages/birthdays): _____

Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons (including where, when and why for each surgery/admission):

_____

_____

_____

_____

_____

Is there anything else you think the doctor should know? _____

_____

_____

There is a $1000 non-refundable fee on all cancelled surgeries. Additionally, if you cancel your surgery within a two week period prior to the scheduled procedure date, 40% of the total surgery cost will be assessed. If you cancel your surgery within one week of the scheduled procedure date, 70% of the total surgery cost will be assessed. If you cancel your surgery within 48 hours of the scheduled procedure date, 100% of the total surgery cost will be assessed at the discretion of the practice. If the surgery date is rescheduled by a patient a $700 rescheduling fee may be applied to the total surgery cost. (*There will be a 3% cancellation fee on all payments made by credit card.).

By signing below, I agree that the above information is complete and accurate to the best of my knowledge and I have read the cancellation policy above.

Signature: _____ Date: _____

# STEIN PLASTIC SURGERY

## Request for Confidential Communications Via Voicemail/Email/Text Messaging/Mail

(Please Print Legibly & Fill In or Correct All Fields)

**Patient Name** _____

Home Phone _____ Work Phone _____

Cell Phone _____ Carrier _____

Birthdate _____ Email _____

Under the Health Insurance Portability and Accountability Act of 1996, you have the right to make reasonable requests to receive confidential communications of your protected health information from Stein Plastic Surgery by alternate means or alternative locations. With your consent, we will only use voicemail, email, text messaging, and/or mail about non-sensitive and non-urgent issues. All communications to or from you, may be part of your medical record. You have the same right of access to such communications as you do the remainder of your medical record. Your email and text messages may be forwarded to another Stein Plastic Surgery staff member for appropriate handling. We will not disclose your emails, text messages or mail unless allowed by state or federal law. Please refer to the Stein Plastic Surgery Notice of Privacy Practices for information as to permitted uses of your protected health information and your rights regarding privacy matters.

### Use of voicemail, unencrypted email, text messages, and mail have a number of risks

These risks include, but are not limited to, the following:

- Voicemail, email and text messages can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Senders can possibly misaddress a voicemail, email, text message, or mail an send the information to an undesired recipient.
- Backup copies of voicemail, email, text messages, or mail may exist even after the sender and/or recipient has deleted his or her copy.
- Employers and on-line services have a right to inspect voicemails, emails and text messages sent through their company systems.
- Voicemail, email, text messages, and mail can be intercepted, altered, forwarded or used without authorization or detection.
- Voicemail, email, text messages, and mail can be used as evidence in court.
- Voicemail, email, text messages, and mail may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.

Stein Plastic Surgery cannot guarantee but will use reasonable means to maintain security and confidentiality of voicemail, email, text messages and mail sent and received. If you consent, you must acknowledge and consent to the following conditions:

- IN A MEDICAL EMERGENCY, DO NOT USE VOICEMAIL, EMAIL, TEXT MESSAGING or MAIL, CALL 911. Do not use voicemail, email, text messaging, or mail for urgent problems. If you have an urgent problem during regular business hours, please call the office. Urgent messages or needs should be relayed by regular telephone communication and may include text messages.
- Emails and mail should not be time-sensitive. While staff tries to respond to email and mail daily, we cannot guarantee that any particular mail or email will be read and responded to within any particular period of time. If you have not heard back from an email within 3 days or mail within a week, please call the office to follow up if we have received it.
- You should speak with Dr. Stein and/or the clinical staff to discuss complex and/or sensitive situations rather than send email, text messages or mail regarding such situations.
- Email, text messages, and mail may be filed into your medical record.

## Request for Confidential Communications Via Voicemail/Email/Text Messaging/Mail (continued)

(Please Print Legibly & Fill In or Correct All Fields)

- Clinical staff will not forward your identifiable email, text messages, or mail to outside parties without your written consent, except as authorized by law.
- You should use your best judgment when considering the use of mail, email, or text message for communication of sensitive medical information. Clinical staff are not responsible for the content of messages.
- Stein Plastic Surgery is not liable for breaches of confidentiality caused by you or any third party.
- It is your responsibility to follow up with the office if warranted.

### Consent for Confidential Communications

By answering yes and signing this form, I am requesting Stein Plastic Surgery communicate with me via my email and/or phone numbers I listed:

| Method | OK to Leave Voicemail | OK to Leave Message with Another Person | Preferred Contact Method(s) | Best Time(s) to Call* |
|---|---|---|---|---|
| ❒ Call Cell Phone | ❒ Yes ❒ No | ❒ Yes ❒ No | ❒ | ❒ Morning ❒ Afternoon ❒ Evening ❒ Emergency Only |
| ❒ Call Home Phone | ❒ Yes ❒ No | ❒ Yes ❒ No | ❒ | ❒ Morning ❒ Afternoon ❒ Evening ❒ Emergency Only |
| ❒ Call Work Phone | ❒ Yes ❒ No | ❒ Yes ❒ No | ❒ | ❒ Morning ❒ Afternoon ❒ Evening ❒ Emergency Only |

**OK to Send Text?**

Text Appointment Reminders ❒ Yes ❒ No

Text Communications That May Contain Protected Health Information with Dr. Stein ❒ Yes ❒ No

Text Office Specials / News ❒ Yes ❒ No

**OK to Send Email?**

Email Appointment Reminders ❒ Yes ❒ No

Email Communication That May Contain Protected Health Information with Medical Staff ❒ Yes ❒ No

Email Office Specials / News ❒ Yes ❒ No

**OK to Send Mail?** ❒ Yes ❒ No

I acknowledge and agree to the following:

- I have read and fully understand this consent form. I have had an opportunity to ask questions and have had such questions answered to my satisfaction; I fully understand the information contained within this consent form.
- The email addresses and phone numbers I listed are accurate and it is my responsibility to update Stein Plastic Surgery in writing with any changes.
- I understand that I may revoke this consent at any time by so advising Stein Plastic Surgery in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

Signature: _____ Date: _____