

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

E-mail

Age

Birthdate

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

Pharmacy Name:

Address:

Phone:

Areas that may interest you:

☐

Blepharoplasty (Eyelid Lift)

Circle: Upper/Lower

☐

Endoscopic Brow/Forehead Lift

☐

Chin Implant

☐

Neck Liposuction

☐

Face or Neck Lift

☐

Rhinoplasty (Nose Reshaping, Septoplasty)

☐

Skin Resurfacing (Laser, Chemical Peel)

How did you hear about Dr. Stein?

Website:

Search Engine:

Social Media:

Magazine:

Friend/Relative:

Doctor:

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 acknowledge 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 Abnormalities	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 / Eye Problems / Dry Eye	Yes	No
Visual Disturbances	Yes	No
Loss of Vision	Yes	No
Acute 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
COVID 19	Yes	No
COVID 19 Vaccine	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? _____

Height: _____ Weight: _____

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 three week period prior to the scheduled procedure date, 50% of the total surgery cost will be assessed. If you cancel your surgery within two weeks of the scheduled procedure date, 75% of the total surgery cost will be assessed. If you cancel your surgery within one week of the scheduled procedure date, 100% of the total surgery cost will be assessed. If the surgery date is rescheduled by a patient within six weeks of the surgery date a \$2000 rescheduling fee will be applied to the total surgery cost. (*There will be a 3% cancellation fee on all payments made by credit card. For payments made through a third-party financing company, an additional cancellation fee will apply to cover non-refundable merchant processing fees. This amount will vary depending on the financing company and plan used). Any surgery rescheduled within six weeks of the scheduled procedure date requires payment of 100% of the surgery fee in order to placed back on the surgery schedule.

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 _____ Cell Phone _____
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 and 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.

STEIN PLASTIC SURGERY

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)
☐ Call Cell Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐
☐ Call Home Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐
☐ Call Work Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐

OK to Send Text?

Text Appointment Reminders ☐ Yes ☐ No

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

OK to Send Email?

Email Appointment Reminders ☐ Yes ☐ No

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

OK to Send US 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: _____