ohiofacial PLASTICS

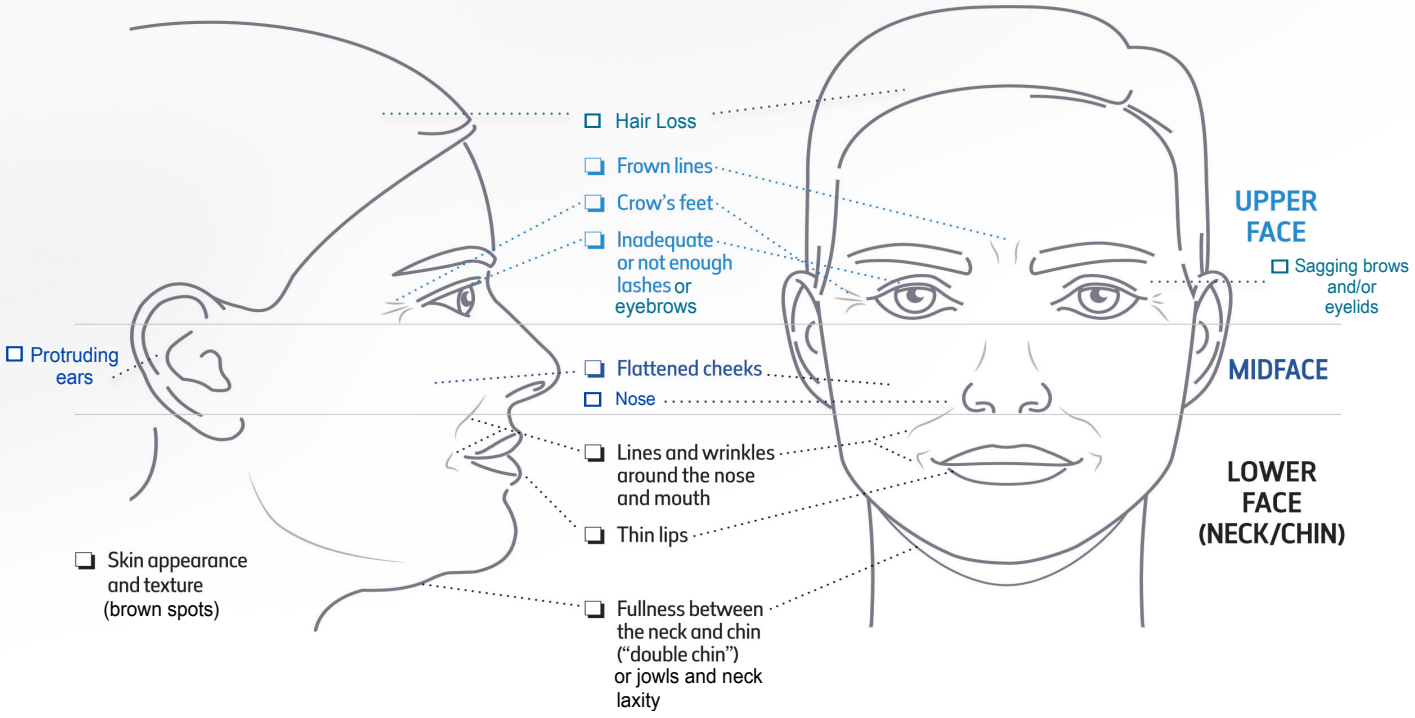
SELF-ASSESSMENT

NAME: _____ DATE OF BIRTH: _____ DATE: _____

What brings you in today? _____

Select which areas of the face concern you on the diagram below.

By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you.



Please complete and return this form to the front office before your consultation.

OHIO FACIAL PLASTICS • SUMIT BAPNA, M.D.

Full Legal Name _____ Today's Date_____

Date of Birth _____ Social Security Number ____-___-____

Email Address _____ Married _ Divorced _ Single _ Other _

Address_____

City_____ State_____ Zip Code_____

Home Phone Number_____ Mobile Phone Number_____

Is it ok if we contact you by: Email Mobile Phone Home Phone Mail

Emergency Contact _____ Phone Number _____

Are there restrictions on contacting you? Y N
If yes, explain_____

Insurance Information

Primary Insurance _____ Policy/Group Number_____
Insured's Name _____ Relationship to Patient _____
Secondary Insurance _____ Policy/Group Number _____
Insured's Name _____ Relationship to Patient _____

Referring Physician & Other Information

Referring Physician _____ Phone Number _____

Primary Care Physician _____ Phone Number _____

How did you hear about us? _____

Primary Reason for Visit _____
I would like to learn more about:
☐ Skin Care and/or Products
☐ Other Cosmetic Procedures:_____
☐ Other Aesthetic Procedures:_____

*AUTHORIZATION: I hereby authorize the physician to furnish information to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as valid as the original.

Name _____ **Date** _____

Patient Name _____

Patient History

Describe your overall health: ☐Excellent ☐Good ☐Fair ☐Poor

Are you presently being treated for any medical conditions? Yes No
If yes, please list:
_____

Are you taking any medications, herbals or home remedies? Yes No
If yes, please list:
_____
_____

Are you taking any medications, used topically, including Retin-A? Yes No
If yes, please list:
_____

Have you taken any steroid preparations over the past year? Yes No
If yes, please list:
_____

Are you taking aspirin, blood thinners, or Vitamin E? Yes No
If yes, please list:
_____

Eye:

Visual loss (one or both eyes)	Yes	No	Cornea Problems	Yes	No
Itching or irritation of eyes	Yes	No	Thyroid eye disease	Yes	No
Blurred or Double Vision	Yes	No	Glasses/Contacts	Yes	No
Previous eye or eyelid surgery	Yes	No	"Dry Eyes"	Yes	No

Details/Type of Surgery:
_____

Nose:

Difficulty breathing through nose	Yes	No	Nasal Allergies	Yes	No
Nose Bleeds	Yes	No	Sinus Conditions	Yes	No
Previous nasal or sinus surgery	Yes	No			

Details/Type of surgery: _____

Face:

Irradiation to face or neck	Yes	No	Facial Skin Problems	Yes	No
Facial Paralysis or weakness	Yes	No			
Previous face or neck surgery	Yes	No			

Details/Type of Surgery: _____

Patient Name _____

Cardiovascular:

Hypertension	Yes	No	Heart Disease	Yes	No
Congenital Heart disease	Yes	No	Heart Murmur	Yes	No
Palpitations/irregular heart beat	Yes	No	Stroke	Yes	No
Previous heart surgery	Yes	No			

Details/Type of surgery: _____

Chest:

Shortness of breath	Yes	No	Chronic Lung disease	Yes	No
Chronic Cough	Yes	No	Asthma	Yes	No

Psychiatric:

Have you ever received psychiatric treatment	Yes	No
If yes, were you hospitalized	Yes	No
Have you ever been diagnosed with a eating disorder (anorexia, bulimia)?	Yes	No

Additional Details _____

Other:

Liver disorder: hepatitis/cirrhosis	Yes	No	Kidney disease	Yes	No
Spinal/back disorder	Yes	No	Bladder disorder or chronic infections	Yes	No
Previous blood clots or Thrombophlebitis	Yes	No	Diabetes	Yes	No
Blood trsnfusion	Yes	No	Cancer	Yes	No
Unusual scarring or keloids	Yes	No	Cold sores/herpes	Yes	No
Auto-immune disease (Lupus, rheumatoid arthritis, etc.)	Yes	No	Currently pregnant?	Yes	No
History of sleep apnea?	Yes	No	HIV positive	Yes	No

Additional Details: _____

Allergies:

Tape Allergy?	Yes	No
Drug Allergy?	Yes	No

If yes, please list:

_____

Social:

Do you smoke? Yes No
If yes, how much? _____

Do you drink more than two (2) alcoholic Beverages a day? Yes No If yes, how many? _____

Patient Name _____

Personal:

Do you get 8 hours of sleep a night? Yes No
Have you experienced menopause? Yes No
Are you currently pregnant or lactating? Yes No

Daily water intake _____
Daily caffeine intake _____

Hair color: Blonde Red Light Brown Brown Black Gray
Eye color: Blue Green Hazel Brown Black

Skin Tone: Pink Olive Native American Hispanic Asian Black

Please list skin care products and cosmetics you currently use:

_____
_____
_____

Do these include Glycolic Acid, Salicylic Acid or Retin – A Yes No

Skin Type: (when exposed to the sun **without protection** for about 1 hour)

1. Always burn, never tan
2. Always burn, sometimes tan
3. Sometimes burn, sometimes tan
4. Always Tan
5. Hispanic, Asian, Mediterranean, Middle Eastern
6. African-American

When were you last exposed to the sun, including a tanning booth?

_____

Do you use chemical or sun-less tanning lotions? Yes No
Are you planning a holiday in the sun? Yes No

Please list other conditions or concerns: _____

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Acknowledgement of Receipt of Privacy

Your privacy is important to us. We create information about you so we may provide you with quality care. We are committed to protecting this information. The Notice of Privacy Practices describes your rights with regard to your health information. This is a summary of the more detailed information contained in out Notice of Privacy Practices.

Your rights include:

- A right to inspect and copy your medical information
- A right to amend your health information
- A right to request restrictions on what information we use or how we disclose your health information
- A right to receive an accounting of certain disclosures we have made of your health information
- A right to receive a paper copy of our Notice of Privacy Practices

These rights do have special restrictions, so it is important that you read the full Notice.

We may use your health information and/or records to:

- Plan for your care
- Help your health care providers communicate and work together to care for you
- Submit bills to pay for your care
- Help health care payers make sure services were actually provided
- Help improve the quality of health care. For example, after your visit we may contact you to see how you are doing and find out how you felt about our service
- Disclose information to certain officials or organizations where we may, or are required to do so by law

I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, and why my confidential health information may be used or shared. I acknowledge that Ohio Sinus Institute physicians and other Ohio Facial Plastics staff may use and share my confidential health information with others in order to arrange for payment of my bill and for issues that concern Ohio Sinus Institute operations and responsibilities.

_____

Date Patient Name Signature of Patient/Responsible Party

Signature of staff member delivering notice: _____

****

Attempt to Deliver Notice of Privacy Practices:

_____

Patient Name Date

However, delivery could not be made because:

_____

_____

Signature of Practice Employee Title Date

ohiofacial PLASTICS

Sumit Bapna, M.D.

Patient Photographic Consent and Release

I _____ consent to the taking of photographs by Dr. Bapna, or his designee, of me or parts of my body in connection with plastic surgery or skin procedures to be performed for medical photo documentation and communication within our practice.

AND

___ I **DO** give permission ___ I **DO NOT** give permission that such photographs may be published in any print, visual or the internet, specifically including, but not limited to, medical journals, textbooks, practice website and social media channels, for the purpose of informing the medical profession or the general public about plastic surgery methods.

Neither I, nor any member of my family will be identified by name in any publication. I understand in some circumstances the photographs may portray features, which shall make my identity recognizable.

I release and discharge Dr. Bapna and associates and all parties acting under the license and authority from all rights from that I may have in the photographs and from any claim that may have relating to such use in a publication, including any claim for payment in connection with distribution or publication of the photographs.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Consent and Release and full understand its terms

_____ _____

Signature Date

_____ _____

Witness/Physician Date

I have read the above Consent and Release. I am a parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on her/her behalf and grant this consent as a voluntary contribution in the interest of the public.

_____ _____

Parent/ Guardian Signature Date