PLASTIC SURGERY NORTHWEST

Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Name: _____ Reason for Visit: _____

Age: _____ Height: _____ Feet _____ Inches Weight: _____ Lbs.

Current Primary care Physician(s): _____

When was the last time you saw a doctor? _____

List all Surgeries (Hospitalization and the Date of Occurrence):

List any major medical conditions you have been diagnosed with (Ie COPD, Diabetes, Asthma, etc):

Do you have or have you had any of the following: (circle for each, give date occurred if Yes)

Aids / HIV	No	Yes	Seizures/Fainting	No	Yes	High Blood Pressure	No	Yes
Arthritis	No	Yes	Facial Pain/Cold Sores	No	Yes	Kidney Problems	No	Yes
Asthma/COPD	No	Yes	Weakness/paralysis	No	Yes	Sinus Problems / Infections	No	Yes
Bronchitis/Pneumonia	No	Yes	Thyroid Problems	No	Yes	DVT/Blood Clots	No	Yes
Cancer	No	Yes	Hay Fever / Allergies	No	Yes	Indigestion/Nausea	No	Yes
Depression/Anxiety	No	Yes	Headaches / Migraine	No	Yes	Heartburn/GERD	No	Yes
Diabetes	No	Yes	Heart Trouble/Attack	No	Yes	Auto Immune Dz	No	Yes
Dizziness / Vertigo	No	Yes	EKG Abnormalities	No	Yes	Hepatitis	No	Yes
Stroke	No	Yes	Chest pain	No	Yes	Chronic Pain	No	Yes

Did you ever smoke? No Yes If yes, how much? _____ Pack(s)/day Date you quit? _____

Do you drink alcohol? No Yes If yes, how much? _____ How often? _____

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Do you use recreational drugs?	No	Yes	If yes, describe:	
Do you have bleeding or bruising problems?	No	Yes	If yes, describe:	
Do you have problems with scarring?	No	Yes	If yes, describe:	
Do you or any family have a history of problems with anesthesia?	No	Yes	If yes, describe:	
Have you ever been on steroids?	No	Yes	If yes, describe:	

List the name of all medications you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency.

List ALL drug and/or latex allergies.

Family History: Please list any major medical problems of your immediate family.
If you are seeing us for cancer please list all family members with your type of cancer

Have you ever been pregnant?
Have you ever, or do you plan to breast feeding?

Is there any chance that you are currently pregnant?

Who do you currently live with?

Is there any thing else you would like to tell your physician?

The above information is accurate and complete to the best of my knowledge.

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Signature **Date**

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the office.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information from Plastic Surgery Northwest, and related organizations.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

This form will be retained in your medical record.

PLEASE SIGN AND RETURN TO OUR OFFICE AT YOUR NEXT APPOINTMENT TIME.

530 S. Cowley St, Spokane WA 99202 | T 509.321.6033 | F 509.232.0003 | PlasticSurgeryNorthwest.com

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Patient's Name _____

Last First

Address _____

Street & Apt # City State

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? r No r Yes E-mail _____

Contact Restrictions: _____

Age _____ Birthdate _____ SSN _____ Sex M F

Preferred Language _____ Race/ Ethnicity _____

Marital Status _____ Spouse's Name _____

How were you referred to Plastic Surgery Northwest? _____

Patient's Employer _____ Occupation _____

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

Address _____

Street & Suite # City State

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____

Street & Apt # City State

Primary Health Insurance Company _____

Policy # _____ Group # _____

Referral Required? r No r Yes Copay? r No r Yes, $ _____

Insured Name: _____ DOB _____ Employer _____

L&I Claim Number _____ Date of Injury? _____ Employment or Auto accident ?

Secondary Health Insurance Company _____

Policy # _____ Group # _____

Referral Required? r No r Yes Copay? r No r Yes, $ _____

Insured Name: _____ DOB _____ Employer _____

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I understand that office visit charges may be payable on the day service is rendered. I authorize Plastic Surgery Northwest to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Plastic Surgery Northwest and myself.

Signature _____ **Date** _____

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PHARMACY PREFERENCE INFORMATION:

To aid in the process of filling your prescriptions our staff can e-scribe or call in your medications (excluding narcotic medications) to the pharmacy of your choice.

PHARMACY NAME:

PHARMACY LOCATION:

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*Please initial the below referenced information you wish to authorize.

_____I hereby give my consent for Plastic Surgery Northwest Physicians or staff to leave information regarding my treatment, results, appointment information, or recommendations on my voicemail at the phone numbers I have provided.

_____I hereby give my permission for Plastic Surgery Northwest Physicians or staff to phone me at my work.

_____I hereby give my permission for Plastic Surgery Northwest Physicians or staff to discuss my billing information and appointment information with the person/persons listed below:

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

_____I hereby give my permission for lab results to be sent to me at the address I have supplied.

I am aware that I may change the above authorizations with a written request at any time. The new authorization will only become effective once a written request is received by Plastic Surgery Northwest's office and is posted by our Privacy Officer.

My signature acknowledges that I have read and agree to this consent form.

Patient Name_____

Patient Signature_____ Date_____

Date Reviewed & Revised:_____ Patient Initials: _____
Date Reviewed & Revised:_____ Patient Initials: _____
Date Reviewed & Revised:_____ Patient Initials: _____

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PHOTO AND VIDEO CONSENT AND AUTHORIZATION

Agreement and capture, disclosure and use of still photos, moving video and computer images

I,_____, authorize the capture, disclosure and use, as noted below, of photographs, video and **accompanying protected health information** related to my healthcare services at Plastic Surgery Northwest ("Media"). I understand that my photo will be taken and placed in my permanent medical record.

Media may also be used or disclosed for:

Y N

Photo albums for the education of Plastic Surgery Northwest patients

Publication in print or visual media, including medical journals, textbooks, educational videos or presentations

Publication on the Plastic Surgery Northwest website or in other advertising media representing and/or marketing Plastic Surgery Northwest and its services and physicians

Published Media may include my image, voice, age, sex, medical condition, treatment, and outcome, but this consent does not authorize the release of written or printed medical records. However, please withhold the following specific information:-

_____

_____

All Media will become the property of Plastic Surgery Northwest and may be retained for the purposes and uses approved in this consent. I understand that Plastic Surgery Northwest may receive compensation for its use and/or disclosure of Media in marketing materials such as websites, media outreach, brochures, television, and/or any other media outlets or for other marketing purposes. I understand and agree that I will not receive any compensation for use of Media and I waive any right for myself, my spousal community or my heirs and assigns to receive any compensation. I agree to hold harmless Plastic Surgery Northwest and its associated physicians and any and all employees from all claims and liabilities whatsoever in law and in equity arising from disclosure and use of Media as authorized in this consent.

I understand that I may refuse to authorize the disclosure and use of any Media and that my refusal to consent will prevent its disclosure and use except solely in connection with healthcare services at Plastic Surgery Northwest, but such refusal will not affect the healthcare services that I receive from Plastic Surgery Northwest. I understand that I have the right to revoke this authorization in writing at any time, but I further understand that revocation will not apply to or cause the retraction of previously published, disclosed or used Media.

By signing below, I acknowledge and certify that I have read, understood and agreed to the terms of this consent, and that I have received a copy of the signed consent.

Signature (patient or person authorized to give permission):	Date:
Printed Name: If signed by person other than patient, please provide relationship:_____	Social Security Number: Date of Birth:

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COSMETIC INTEREST QUESTIONNAIRE

Patient name: _____

Areas of interest or concern to you (please check all that apply):

- ☐ Botox® Cosmetic
- ☐ Juvederm®
- ☐ Skin rejuvenation
- ☐ Retin-A
- ☐ Acne
- ☐ Chemical peels
- ☐ Laser resurfacing
- ☐ Laser treatments
- ☐ Spider vein treatments
- ☐ Skincare advice
- ☐ Sunscreen advice
- ☐ Birthmarks
- ☐ Liver spots/age spots
- ☐ Leg veins
- ☐ Facials and eye treatments
- ☐ Hair removal
- ☐ Facial veins
- ☐ Brow/Eyelash Tinting

☐ Latisse
☐ Other, please specify: _____

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number:

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		**True Age**		**Older Than**
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		**Somewhat Concerned**		**Very Concerned**
1	2	3	4	5

How did you hear about us?

_____