PATIENT INFORMATION FORM
Please Print

DATE: _____
PATIENT NAME: _____ BIRTHDATE: _____
ADDRESS: _____ PHONE: _____
CITY: _____ STATE: _____ ZIP: _____
AGE: _____ SEX: M ( ) F ( ) MARITAL STATUS: ( ) MARRIED ( ) SINGLE ( ) DIVORCED ( ) WIDOWED
SOCIAL SECURITY #: _____ FAMILY DOCTOR: _____
RESPONSIBLE PARTY IF DIFFERENT FROM ABOVE: _____
ADDRESS: _____PHONE: _____
EMPLOYER: _____OCCUPATION: _____ PHONE: _____
NEAREST FRIEND OR RELATIVE: _____ PHONE: _____
REFERRED BY: _____ PERSONAL CELL. PHONE:_____
E-MAIL ADDRESS: _____ OTHER PHONE: _____

ARE YOU INTERESTED IN FINANCING: YES ( ) NO ( )

ARE YOU INTERESTED IN SKIN CARE, BOTOX, FILLERS? YES ( ) NO ( )

HEALTH HISTORY (*PLEASE ANSWER ALL QUESTIONS*)

WHAT WOULD YOU LIKE DR. GENTILE TO HELP YOU WITH?
_____
_____

DOES YOUR CONCERN ABOUT YOUR APPEARANCE PREVENT YOU FROM DOING CERTAIN ACTIVITIES? (SUCH AS GOING TO PARTIES, ETC.) _____
_____

WHEN DOES IT BOTHER YOU THE MOST? _____
_____

ON A SCALE FROM 1-10, COMPARED TO THE REST OF THE POPULATION

How do you rate your overall attractiveness? (1-10) _____ (1=least and 10=best)

How do you rate your area of concern? (1-10) _____ (1=least and 10=best)

YES NO Do you think plastic surgery can turn your life around? (If yes, explain) _____
_____
_____

YES NO Have you ever consulted a plastic surgeon? (Please give details, if you wish to.)
_____
_____

YES NO Have you had any plastic surgery? (Please describe, including dates.)
_____

YES NO Were you satisfied with the results of any plastic surgery you may have had?
_____

Have you ever had any of the following in the skin of the face, eyelids, scalp, or neck:
____Dermabrasion, Laser, Chemical Peels ____Oral Herpes ____Loss of Hair ____Acne
____Scars, Moles, Rashes, other skin lesion ____Radiation Treatment ____Skin Cancer

PLEASE SEE NEXT PAGE!
Please list any surgery you have had. (ex.: Hernia, T & A, C-section, D & C, laparoscopy, Appendectomy, etc)
_____
_____

_____

Please describe any hospital admission. (ex. Pneumonia, Diabetes)

_____

_____

YES NO Have you ever had any dental procedure complications? If yes, please describe:
_____

YES NO Do you heal well?

YES NO Do you bruise easily?

YES NO Do you scar badly?

Please describe your health:

_____

_____

Weight _____ Height _____

YES NO Do you have High Blood Pressure?

YES NO Have you had Anemia (low blood counts)? Have you ever had an episode of Syncope (passing out)? Does anybody in your family have Anemia?

YES NO Have you ever had an irregular heartbeat?

YES NO Have you ever had a heart attack?

YES NO Have you had "Angina" (pain in the chest with exertion), or Pleuritic pain?

YES NO Have you ever taken heart medicines or high blood pressure medicines? (If yes Please list.) _____

YES NO Do you become short of breath easily? Have you ever had an episode of difficulty breathing?

YES NO Do you have: ____Asthma ____Sleep Apnea ____Bronchitis ____Emphysema

YES NO Do you snore or fall asleep easily during the day?

YES NO Do you wake up during the night with choking sensation?

YES NO Have you ever had any Collagen Diseases? (ex. Lupus, Rheumatoid Arthritis)

YES NO Have you ever had a "Stroke"?

YES NO Have you ever had any Nervous System Problems? Seizures or Epilepsy?

YES NO Have you ever had a muscle or neuromuscular disorder or muscle spasm?

YES NO Have you ever had a severe head injury?

YES NO Have you ever had excessive bleeding after surgery?

YES NO Have you ever had any blood transfusions?

YES NO Have you ever had any major or serious injuries?

YES NO Have you ever had any urinary tract or kidney problems? Dark or chocolate colored urine?

YES NO Have you ever had "yellow jaundice", Hepatitis, or any other liver disease?

YES NO Have you ever had stomach ulcer or any abdominal/digestive system problems?

YES NO Have you ever had any infectious diseases (HIV, AIDS or other serious viral syndromes) common colds or flu or wound infections such as MRSA ?

YES NO Have you ever been diagnosed as a diabetic?

YES NO Have you ever had any endocrine system problems? (ex.: Thyroid)

YES NO Have you ever had:

____Varicose Veins _____Phlebitis (or "milk legs")
____Blood clots in your legs _____Pulmonary embolism

YES NO Have you ever had any reproductive system problems? (Ob-Gyn)

YES NO Do you take contraceptives (birth control pill) or replacement hormones?

YES NO Have you ever had treatment for Cancer? (Please describe and list dates.)

_____
_____

YES NO Have you ever received counseling or treatment for a mental condition, emotional problem, or depression? (Please describe and list dates.)

_____
_____
_____

YES NO Have you ever taken antidepressants or other medication prescribed to treat mental illness or any other psychiatric disorder? (if yes, please list)_____

_____

YES NO Have you ever suffered headaches: ___Migraine ___ Tension ___Other
Please describe: _____

YES NO Have you ever had any congenital deformity?

YES NO Were you ever diagnosed with a blood clotting disorder (antiphosphlolipid syndrome, homocystinemia) or other acquired or genetic syndromes/disorders?

YES NO Have you ever taken Cortisone, Prednisone, or any other Cortisone-type or Steroid medication by injection or in tablet form?

What medications do you take now?

Medication_____Dosage_____Frequency_____Purpose_____

_____
_____
_____
_____
_____
_____

YES NO Are you, or have you ever taken:

____Aspirin ____Other Hormones ____Other Antibiotics
____Advil/Motrin ____Valium ____Novacaine

____Ephedra	____Librium	____Xylocaine
____Accutane	____Steroids	____Penicillin
____Green Tea,Gingko	____Tylenol	____Keflex
____Garlic	____Codeine, Percodan/cet	____"Bete Blockers"
____Herbs of any sort	____Demoral, Morphine	____Diuretics
____Diet Pills	____Anti-Depressants	____Marine Omega-3 Fatty Acids
____Female Hormones	____Tranquilizers	____Other Fish Oil Supplements
____Birth Control Pills	____Inderal, Verapamil	____Calcium Channel Blockers

YES NO Have you ever had a bad reaction or an allergic reaction to any medication? or adhesive tape? (Please describe reaction from which medication.)

_____

_____

YES NO Are you allergic to iodine shellfish, shrimp, or oysters?

YES NO Are you allergic to soy, peanuts, avocados, kiwi or bananas?

YES NO Have you or any family member ever had reaction or allergy to anesthesia?

YES NO Have you or any family member experienced Malignant Hyperthermia or high temp (fever) after exercise or anesthesia?

YES NO Is there a history of blood clots or pulmonary embolism in you or your family?

YES NO Do you, or have you ever used any drugs for recreational purposes?

____Marijuana ____Cocaine/Crack ____LSD/Acid

____Heroin ____Other _____

YES NO Do you smoke? How long? _____ How many per day?_____

YES NO Please describe your alcohol consumption? _____ glasses/cans of ____per day ____per week

YES NO How many pregnancies have you had? _____ How many alive? _____

YES NO **Are there any other details or medical conditions that you have not mentioned that you feel are pertinent and if so, please describe:**

_____

_____

_____

_____

_____

_____

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and had an opportunity to read the office's Notice of Privacy Practice's, the Health Insurance Portability and Accountability Act (HIPAA) which explains how my medical information will be used and disclosed. In reading this information, I understand my rights as a patient and also I understand that I am entitled to receive a copy of this document.

If it is necessary for Dr. Gentile or his staff to notify me of personal health information, I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone (_____)_____ ☐ Written Communication
☐ O.K. to leave message with detailed information ☐ Ok to mail to my home address
☐ Leave message with call back number only ☐ Ok to Email or fax:_____

☐ Work Telephone (_____)_____ ☐ Cellular Phone (_____)_____
☐ O.K. to leave message with detailed information ☐ Ok to leave message on voice mail
☐ Leave message with call back number only

☐ **Personal health information may be released to the following nearest friend or relative(s):**

Name: _____ Name: _____

Telephone: (_____)_____ Telephone: (_____)_____

If you are financing or paying with a credit/debit card (Visa, Discover, MasterCard or American Express), be advised that in case any monetary dispute arises, you are giving Dr. Gentile permission and agreeing by signing this document to release your medical records to your Credit/Debit Card company, Insurance, Financial or other Loan Co. and therefore you are waiving your privacy protection under HIPAA (Health Ins. Portability and Accountability Act).

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative (Please Print) Description of Personal Representative's Authority

Yes ☐ **By checking the box Yes, you give consent and thereby permission to receive our email newsletter.**
My email address is: _____
_____
Initials

CONSENT TO PHOTOGRAPHS

I hereby authorize and give permission to Dr. Gentile and/or his assistants to take such photographs of me as he may desire before, during, and after treatment.

_____
Signature of Patient

MUTUAL AGREEMENT TO MAINTAIN PRIVACY

Dr. Herve Gentile and A Better You Cosmetic Surgery Center (collectively labeled "Physician") agree to maintain Privacy of _____ (patient name) as outlined in the HIPAA form. Dr. Herve Gentile takes pride in being able to extend a greater degree of privacy than is required by HIPAA, state confidentiality mandates, and common law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, HIPAA forbids physicians from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party

perform the marketing. While personal data is never technically in the possession of the company selling it products or services, the patient can still be targeted with unwanted marketing information. Physicians believe this is improper and may not be in the patients' best interest. Accordingly, Dr. Gentile agrees not to provide any list for marketing directly to patients. Regardless of legal privacy loopholes, Dr. Gentile will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

In consideration for treatment and the above noted patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Physician and his practice, expertise and/or treatment- the sole exceptions being communication to a confidential medical-peer review body; to another healthcare provider; to a licensed attorney; to a governmental agency; in the context of a legal proceeding; or unless mandated by law. Publishing is intended to include attribution by name, by pseudonym or anonymously. If Patient does prepare commentary for publication about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment is in further consideration for additional privacy protections provided by Physician. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary. Physician has invested significant financial and marketing resources in developing the practice. In addition, Patient will not denigrate, defame, disparage, or cast aspersions upon the Physician, and (ii) will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in any such activity. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage a Physicians practice.

Physician feels strongly about Patients' privacy as well as the practices' right to control its public image and privacy. Both Physician and Patient will work to prevent the publishing or airing of commentary about the other party from being accessed via Internet, blogs, or other electronic, print, or broadcast media without prior written consent. Finally, this Agreement shall be in force and enforceable (and fully survive) for a period of the longer of (a) five years from Physician's last date of service to Patient; or (b) three years beyond any termination of the Physician-Patient relationship. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients.

Patient and Physician acknowledge that breach of this Agreement may result in serous, irreparable harm. In addition to compensation for consequential damages, Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

SO AGREED THIS _____ DAY OF _____, 201____. _____
(patient signature)

Herve' F. Gentile, MD
A Better You Cosmetic Surgery Center

_____
(printed name)