

Registration Form

PATIENT NAME (Last, First, Middle Initial):				Maiden Name	DATE:
Marital Status S - M - W - DIV - SEP	Date of Birth:	Age:	Sex:	Race: ☐ Caucasian ☐ Asian ☐ Hispanic ☐ Indian ☐ African American	
Street Address: ☐ Permanent ☐ Temporary City State Zip				Home Phone:	
Patient's Employer:		Occupation: (Student ☐ Part-time ☐ Full-time)		Business Phone:	
Social Security Number:		Cell Phone Number		Cell Phone Provider:	
Emergency Contact:		Relationship:		Telephone Number:	
<i>*Email will be used for most all communication from our office. It may also be used to keep you informed of all promotions, discounts, education, etc This information will <u>NOT</u> be shared.</i> Email Address:					

-- IF PATIENT IS A MINOR OR STUDENT PLEASE FILL OUT THIS SECTION --

Mother's Name:	Full Address:	Home Phone Number:	Social Security Number:
Mother's Birth Date:	Mother's Employer:	Occupation:	Business Phone Number:
Father's Name:	Full Address:	Home Phone Number:	Social Security Number:
Father's Birth Date:	Father's Employer:	Occupation:	Business Phone Number:

INSURANCE

(PLEASE PROVIDE A COPY OF INSURANCE CARD – FRONT & BACK)

PRIMARY	NAME OF INSURANCE	INSURANCE ADDRESS		
		PHONE #		
	SUBSCRIBER ID #/CLAIM #	GROUP #		
	SUBSCRIBER	DATE OF BIRTH	RELATIONSHIP	
	SUBSCRIBER ADDRESS			
SECONDARY	EMPLOYER	OCCUPATION	SOCIAL SECURITY #	
	NAME OF INSURANCE	INSURANCE ADDRESS		
		PHONE #		
	SUBSCRIBER ID #/CLAIM #	GROUP #		
	SUBSCRIBER	DATE OF BIRTH	RELATIONSHIP	
SUBSCRIBER ADDRESS				
EMPLOYER			OCCUPATION	SOCIAL SECURITY#

PHARMACY INFORMATION:

Name of Pharmacy: _____ Address: _____
 Phone: _____ Fax: _____

If applicable: Date of ACCIDENT or INJURY _____ Due to : ☐ Work ☐ Auto ☐ Other

I request that payment of authorized insurance benefits be made to Bellissimo Plastic Surgery LLC for any services furnished to me by that physician or supplier. I authorize the release of medical information (and/or photographs) about me needed to determine the benefits or the benefits payable for related services to my insurance company and its agents.

SIGNATURE: _____ DATE: _____

Bellissimo Plastic Surgery & Medi Spa Medical History

Patient Name: _____ D.O.B: _____ Age: _____

Stated Height: _____ Stated Weight: _____ Blood Pressure: _____

Referring Physician (Address & Phone): _____

Primary Care Physician (Address & Phone): _____

How did you hear about us? _____

Other Physicians you see (example: Heart, Lung, Endocrine specialist):

_____ M.D. Type: _____

_____ M.D. Type: _____

Reason for visit: _____

Have you ever seen another surgeon for the same problem or concern? ☐ Yes ☐ No

Past Medical History: (Please circle yes or no)

Neurological:

Migraine/ Headache	Yes	No
Fainting	Yes	No
Stroke / TIA / Paralysis	Yes	No
Seizures	Yes	No
Glaucoma	Yes	No

Brain Aneurysm / Head Injury	Yes	No
Macular Degeneration	Yes	No
Retinal Detachment	Yes	No
Blindness	Yes	No
Other:	Yes	No

Pulmonary:

Asthma	Yes	No
Aspiration	Yes	No
Sleep Apnea	Yes	No
Pneumonia / Bronchitis	Yes	No
Emphysema / COPD	Yes	No

Deep Vein Thrombosis	Yes	No
Pulmonary Embolism	Yes	No
Pulmonary Hypertension	Yes	No
Lung Cancer / Tuberculosis (TB)	Yes	No
Other:	Yes	No

Cardiac:

High Blood Pressure	Yes	No
Elevated Cholesterol	Yes	No
Angina/Chest pain	Yes	No
Heart Attack	Yes	No
Irregular Heart Beat	Yes	No
Atrial Fibrillation	Yes	No

Congestive Heart Failure	Yes	No
Heart Murmur / Valve Disease	Yes	No
Pacemaker / Defibrillator	Yes	No
Rheumatic Fever / Heart Infection	Yes	No
Heart Surgery / Angioplasty	Yes	No
Coronary Artery Disease	Yes	No
Other:	Yes	No

Gastrointestinal:

Motion Sickness	Yes	No
Diarrhea	Yes	No
Gallstones	Yes	No
Reflux / Heartburn/	Yes	No
Hiatal Hernia		

Peptic Ulcers	Yes	No
Liver Disease / Cirrhosis / Jaundice	Yes	No
Irritable Bowel Syndrome	Yes	No
Other:	Yes	No

Bellissimo Plastic Surgery & Medi Spa Medical History

Gyn/Breast:

Breast Cancer/ Mastectomy	Yes	No
Breast Disease	Yes	No
Endometriosis	Yes	No

Uterine Cancer	Yes	No
Prolapse	Yes	No
Other: _____	Yes	No

Age of first period _____
Number of pregnancies _____

Date of last period _____
Number of births _____

Age of menopause _____
Breast Feeding _____

Last Mammogram _____

☐ Reported as normal by patient

☐ Report interpreted as normal

Musculoskeletal:

Artificial joint / prosthesis	Yes	No
Multiple Sclerosis	Yes	No

Osteoporosis	Yes	No
Other: _____	Yes	No

Skin:

Cancer	Yes	No
Psoriasis	Yes	No
Do you go to a tanning bed?	Yes	No
How do you tan? [] Burn [] Usually Burn [] Sometimes Burn [] Rarely Burn [] Never Burn		

Eczema	Yes	No
Other: _____	Yes	No
Do you use sunblock?	Yes	No

Hair:

Hair thinning	Yes	No
Baldness	Yes	No
Hair Shedding	Yes	No

Psychiatric:

Depression / Anxiety	Yes	No
ADHD / Bi-Polar	Yes	No
Eating Disorder	Yes	No

Schizophrenia	Yes	No
Dementia	Yes	No
Other: _____	Yes	No

Endocrine:

Diabetes	Yes	No
(if yes, insulin dependent?)	Yes	No

Thyroid Disease	Yes	No
Hypoglycemia	Yes	No
Other: _____	Yes	No

Renal/Genitourinary:

Kidney Stones	Yes	No
Kidney Disease	Yes	No
Kidney Failure	Yes	No

Prostate Disease	Yes	No
Frequent Urinary Tract Infections	Yes	No
Other: _____	Yes	No

Vascular:

Aneurysm	Yes	No
Peripheral Vascular Disease/ poor circulation	Yes	No

Vasculitis	Yes	No
Varicose Veins	Yes	No
Other: _____	Yes	No

Rheumatology:

Rheumatoid Arthritis	Yes	No
Osteoarthritis	Yes	No
Lupus / Scleroderma	Yes	No

Raynaud's Disease	Yes	No
Fibromyalgia	Yes	No
Other: _____	Yes	No

Hematology / Infectious Disease:

Anemia	Yes	No
Bleeding Tendencies	Yes	No
Hemophilia	Yes	No
Sickle Cell	Yes	No
Leukemia / Lymphoma	Yes	No

Sexually Transmitted Disease	Yes	No
Hepatitis	Yes	No
HIV / AIDS	Yes	No
Blood Transfusions	Yes	No
Other: _____	Yes	No

Cancer/ Malignancy:

Location:		
Chemotherapy	Yes	No

Radiation	Yes	No
Date finished treatment: _____		

Bellissimo Plastic Surgery & Medi Spa Medical History

Past Surgical History: (Please list name of procedure and date.)

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Medications: (Please list current medications and dosages.)

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

Drug Allergies: YES / NO

List: _____

Reactions: _____

Do you have an allergy to Latex? YES NO

Do you have an allergy to Codeine? YES NO

Have you ever been on Accutane? YES NO

If yes, when: _____

Social History:

- | | |
|--|---|
| 1. Occupation: _____ | 4. Do you drink alcohol?: Yes No
How much: _____ How often?: _____ |
| 2. Single/ Married/Separated/Divorced/Widowed
(circle one) | |
| 3. Have you ever used tobacco? Yes No Type: _____
If you quit using tobacco, when? _____ | 5. Do you use recreational drugs? Yes No
If yes, # of packs per day?: _____ for # of years?: _____ |

Family History: Please list any family medical history/problems.

	Age	Diseases	Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling	_____	_____	_____

Bellissimo Plastic Surgery & Medi Spa Medical History

_____ There has been no change in my medical history in the past 6 months.

ACKNOWLEDGEMENT:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Bellissimo Plastic Surgery of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Patient Signature: _____ **Date:** _____



New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Bellissimo Plastic Surgery & Medi Spa originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the many health professionals who contribute to my care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided; and
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Policies that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Bellissimo Plastic Surgery & Medi Spa is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Bellissimo Plastic Surgery & Medi Spa reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Bellissimo Plastic Surgery & Medi Spa change their notice, they will give a revised notice to the patient upon the next office visit.

I wish to have the following restrictions to the use or disclosure of my health information:

Due to changes in healthcare and technology, Bellissimo Plastic Surgery & Medi Spa has the ability to provide certain information via email and/or text messaging. If you wish to receive messages from us in this way, please fill out the information below. Bellissimo Plastic Surgery & Medi Spa does not share the names, email addresses, or telephone numbers of our patients with any other company.

I authorize Bellissimo Plastic Surgery & Medi Spa to contact me via email at:

I consent to receiving text messages/appointment reminders from Bellissimo Plastic Surgery & Medi Spa at:

(_____)_____

I understand that text messages are transmitted over a public network onto a personal telephone and as such may not be secure. For this reason, the practice will not transmit PHI via text message. Please call the office directly to discuss issues related to your care.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

Patient Signature (or personal representative)

Date

FOR OFFICE USE ONLY

[] Consent received by _____ on _____ []

Consent refused by patient, and treatment refused as permitted.

[] Consent added to the patient's medical record on _____



PATIENT CONSENT AND RELEASE OF MEDICAL PHOTOGRAPHY

I have consented to the taking of photography, audio/visual recordings or other images of me by Bellissimo Plastic Surgery & Medi Spa, which will become part of my medical record. I understand that my photographs, video, digital and other images may be recorded to document and assist with my care. I acknowledge that the Practice will own these images, but that I will be allowed access to view them or obtain copies of them as part of my medical record. I also understand that the images that identify me can be released and/or used outside the Practice only upon written authorization from me.

I hereby authorize Bellissimo Plastic Surgery, LLC ("Bellissimo") to use pre-operative, intra-operative and post-operative photography for publication, or republication, in any print, visual or broadcast media, including, but not limited to, showing these images on public or commercial television, electronic digital networks, the Internet, and web sites or web pages, for purposes of medical education, patient education, viewing by perspective patients, lay publications, publications for marketing and/or advertising, newspaper and magazine articles, or during lectures to medical or lay groups.

Neither I, nor any member of my family, will be identified by name in any publication. Although measures will be taken to reduce or eliminate identifying features, the possibility remains that someone may recognize me.

I discharge all rights that I may have in the photographs and I release and discharge, Bellissimo, its assigns and licenses, from any claim that I may have relating to such use and publication, including any claim for payment in connection with distribution or publication of the photographs.

I understand that if I allow my images be used in publications, I have the right to revoke this consent up until the time the images are accepted for publication. Once the images have been published, I may not revoke my consent. Anonymity cannot be guaranteed in publications.

I have been provided the opportunity to ask questions concerning medical photography and understand that refusal to consent will not affect my medical care. If the patient is under 18 years of age, I verify that I am the parent or guardian of patient and that I will sign for the patient.

I certify that I have read the above authorization and release and fully understand its terms, intending to be legally bound hereby.

Initials

_____ I agree and authorize the use of my photos.

_____ I **DO NOT** authorize the use of my photos.

Patient Name Printed: _____

Signature of Patient (Parent/Guardian): _____

Date: _____

Witness: _____ Date: _____

Notice of Privacy Practices Summary

Our practice has a long- standing commitment to confidentiality and protecting the privacy of patient information, which includes any information related to your health, treatment or payment for your treatment that can identify you. Our privacy practices are in accordance with applicable federal and state laws.

New federal legislation requires that we have a "Notice of Privacy Practices". A copy of the notice for our practice is available at our front office. This notice explains how we protect your privacy, as well as your legal rights regarding your medical information. This is a brief summary of the content of the "Notice of Privacy Practices." It is not a complete listing of how we use and share your health information.

We may use and disclose your information without your consent:

- To provide treatment to you
- To coordinate your care with other providers
- To conduct standard health care operations business functions
- To bill and receive payment for the services we provide to you, including billing your insurance company or other party responsible for your bills
- To comply with pertinent government agency reporting requirements
- To meet other special reporting requirements as described in the Notice

(Note that information related to behavioral health, drug and alcohol services and AIDS/ HIV are protected by additional state laws.)

We can share your health information with family and /or friends who you agree can have this information. You can give verbal permission for these disclosures.

All other use of your health information will be made only with your specific written permission, or authorization.

You have the following legal rights regarding your health information:

- Right to see your medical record
- Right to have a copy of your medical record (there may be a charge for this)
- Right to ask for a list of who has seen your health information for any reason other than treatment, payment or other health care operations
- Right to ask for more restrictions on the use of your health information. (We are not required to agree to your request.)
- Right to ask for special confidential communication from our practice. (We are not required to agree to unreasonable requests.)
- Right to ask for a change to be made to your medical record
- Right to a copy of our "Notice of Privacy Practices"
- Right to file a complaint if you feel your privacy was violated



Acknowledgement of Receipt of Notice of Privacy Practices

Bellissimo Plastic Surgery & Medi Spa has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information. You may review our current notice prior to signing this acknowledgement.

I acknowledged that I have received the Notice of Privacy Practice for Bellissimo Plastic Surgery & Medi Spa.

Name of Patient (Printed or Typed)

DOB

Signature of patient (or personal representative)

Date

(Personal Representative is required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Personal Representative to Patient

Please specify to whom other than yourself, we may release your protected health information (PHI) including lab or test results and diagnosis:

Name: _____

Name: _____

I, _____ authorize Bellissimo Plastic Surgery & Medi Spa
Signature of patient (or personal representative)

to contact me and/or named authorized person(s) and to convey PHI and assume responsibility to notify Bellissimo Plastic Surgery & Medi Spa whenever this information changes.

FOR OFFICE USE ONLY

I have provided the above-named patient or patient representative with the Notice of Privacy Practices for Bellissimo Plastic Surgery & Medi Spa.

Employee Signature

Date