|  |  |
| --- | --- |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex M[ ]  F[ ]  T [ ]  Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PH#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Consent to Receive Text Messages/ Voicemails/ Emails:**I authorize Webb Aesthetic Plastic Surgery & Med Spa (WAPS) to contact me by SMS text message/ data rates may apply. I know that I am under no obligation to authorize WAPS to send text messages or emails. I may opt out of receiving these communications at any time.**May we leave a voice message?** [ ]  **Yes [ ]  No Home \_\_\_\_\_Cell\_\_\_\_\_****May we text you?** [ ]  **Yes [ ]  No****Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****May we email you about appts and specials? Yes or No**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_Name of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ] Married [ ]  Single [ ]  Divorced [ ]  WidowedSpouse Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**In Case of Emergency, Contact:**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Ph#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**How Did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Other than you and healthcare providers involved in your care, whom may we talk with about your health care information?****Name/ Phone**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Patient Financial Responsibility**I understand WAPS does not accept any type of insurance for cosmetic procedures. I agree to be responsible for all costs involved in my procedures prior to services rendered. Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_**Consent for Purposes of Treatment, Payment, and Healthcare Operations**I authorize WAPS physicians and staff to render medical treatment and evaluation needed. I further authorize order of x-rays, injections, or other diagnostic tests and treatments that may be necessary. I hereby give my consent to use and disclose, for the purpose of carrying out treatment and payment or healthcare operations, all protected health information contained in the patient record of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I understand that this consent is valid until it is revoked by me. I understand that I will not be able to revoke this consent in cases where my provider has referred to it for purposes of disclosing my health information. Written revocation of consent must be sent to the physician’s office. Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_**Acknowledgement- Notice of Privacy Practices**I hereby acknowledge receipt of WAPS’ Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential protected health information. I have reviewed WAPS’ Notice of Privacy Practices. I understand that WAPS reserves the right to change its privacy practices that are described in the Notice. I also understand that any Revised Notice will be posted on WAPS’s website, available at the office, or mailed upon request. Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY:** |
| **General**[ ]  Chills[ ]  Depression[ ]  Stress[ ]  Dizziness/Fainting[ ]  Fever[ ]  Headaches[ ]  Loss of Sleep[ ]  Numbness[ ]  Sweats[ ]  Seasonal Allergies[ ]  Any complications with sexual function **Muscle/Joint/Bone Pain, weakness, numbness**[ ]  Arm [ ]  Hips[ ]  Back [ ]  Legs[ ]  Feet [ ]  Neck[ ]  Hands [ ]  Shoulders**Genito-Urinary****[ ]** Blood in urine[ ]  Frequent urination**[ ]** Lack of bladder control[ ]  Painful urination[ ]  Kidney Stones | **Gastrointestinal**[ ]  Poor Appetite[ ]  Bloating[ ]  Bowel Changes[ ]  Constipation[ ]  Diarrhea[ ]  Excessive thirst[ ]  Gas[ ]  Hemorrhoids[ ]  Indigestion[ ]  Nausea[ ]  Rectal bleeding[ ]  Stomach pain[ ]  Vomiting[ ]  Vomiting blood**Cardiovascular/Lungs****[ ]** Chest pain[ ]  High [ ]  Low blood pressure[ ]  Irregular/rapid heart beat[ ]  Poor circulation[ ]  Swelling of ankles[ ]  Varicose veins[ ]  Coughing[ ]  Wheezing | **Eyes, Ears, Nose, Throat****[ ]** Bleeding gums[ ]  Blurred vision[ ]  Crossed eyes[ ]  Difficulty swallowing[ ]  Earache/Ear discharge[ ]  Hay fever[ ]  Loss of hearing[ ]  Nosebleeds[ ]  Persistent cough[ ]  Ringing in ears[ ]  Sinus problems[ ]  Vision- Flashes/Haloes **Skin****[ ]** Bruise easily[ ]  Hives[ ]  Itching/Rash[ ]  Change in moles[ ]  Scars[ ]  Sore that won’t heal [ ]  Keloids **Women Only****[ ]**  Abnormal pap smear[ ]  Bleeding between periods[ ]  Breast Lump[ ]  Extreme menstrual pain[ ]  Nipple discharge[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Women Only Continued**Date of last menstrual period\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last Pap smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last mammogram:\_\_\_\_\_\_\_\_\_\_\_\_**Abnormal Mammogram Results:**[ ]  Yes [ ]  No**Where was your Mammogram performed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Are you Pregnant?**[ ]  Yes [ ]  No**1st degree relative with cancer:**[ ]  Yes [ ]  NoRelationship to relative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Family History of blood clot:**[ ]  Yes [ ]  NoRelationship to relative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**History of Miscarriage:**[ ]  Yes [ ]  No |
| **Check conditions you have or have had in the past** |
| [ ]  AIDS[ ]  Appendicitis[ ]  Arthritis [ ]  Asthma[ ]  Breast Lump[ ]  Cancer[ ]  Cataracts[ ]  COPD[ ]  Intestinal Disease[ ]  Heart Attack[ ]  Diabetes | [ ]  Chemical Dependency[ ]  Chicken Pox[ ]  Emphysema[ ]  Epilepsy[ ]  Heart Disease[ ]  Hepatitis[ ]  A [ ]  B[ ]  C[ ]  Herpes[ ]  High Cholesterol[ ]  Gall Bladder Disease[ ]  Pace Maker  | [ ]  HIV Positive[ ]  Kidney Disease[ ]  Liver Disease[ ]  Measles[ ]  Migraine Headache[ ]  Multiple Sclerosis[ ]  Mumps[ ]  Ulcers[ ]  Lupus or Other Connective Tissue Disease[ ]  Pneumonia  | [ ]  Polio [ ]  Prostate Problem[ ]  Rheumatic Fever[ ]  Stroke[ ]  Thyroid Problems[ ]  Tuberculosis[ ]  Venereal Disease[ ]  Bleeding Disorders/ Clotting Disorder (IE: Factor V Leiden, Von Willebrand Disease) |
| **FAMILY HISTORY**Date of last Physical Exam: \_\_\_\_\_\_\_\_\_ **Primary Physicians Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physicians Ph #:\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_****Father** [ ]  Deceased [ ]  Alive  **Mother** [ ]  Deceased [ ]  Alive **Siblings [ ]** Deceased [ ]  Alive Cause of Death: \_\_\_\_\_\_\_\_\_\_\_\_ Cause of Death: \_\_\_\_\_\_\_\_\_\_\_\_ Cause of Death: \_\_\_\_\_\_\_\_\_\_\_\_Other family history: (Distant Relatives): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please list any surgeries you have had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**HAVE YOU EVER EXPERIENCED ANY REACTION FROM ANESTHESIA:** [ ]  Yes [ ]  No If yes, Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Medication/ Allergies**List medications you are currently taking: (or you may provide a list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you **allergic** to any medications or substances?­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street, City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Health Habits**Check which ones you use and how much:[ ]  Caffeine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Tobacco/ Nicotine/ Vape: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Alcohol: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Street drugs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Exercise: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in my/child health or insurance information. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Patient, Parent or Guardian Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient |