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| 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  Widowed  Spouse 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  No Relationship to relative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Family History of blood clot:**  Yes  No  Relationship 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 | | | | | |