BAY AREA ESTHETICS

New Patient Information

(Please review and complete the entire packet)

Information entered on this packet will be kept confidential and will not be released without your written consent.

Today's Date: ____/____/_____ Location of today's visit (circle one): San Francisco / Sonoma

Patient's Name (first, middle, last): _____, _____, _____

Street Address: _____

City, State, Zip: _____

Phone Numbers: Home (_____)_____, Cell: (_____)_____

Email Address: _____

Date of Birth: ____/____/_____, Age: _____, Height: _____'_____" Weight: _____ (lbs)

Gender (circle one): Female / Male / Trans-F / Trans-M / Non-binary

Emergency Contact Name (first, middle, last): _____, _____, _____

Emergency Contact Phone Numbers: Home (_____)_____, Cell: (_____)_____

How did you hear about our office (check all that apply)?

- ☐ A physician referred me (name, office #): _____, (_____)_____
- ☐ A friend referred me (first, last name): _____, _____
- ☐ Web / Social Media (circle all that apply): Google, Yelp, Real Self, Facebook, Instagram, Our Website
- ☐ Other: _____

What brings you to the office today? Please be as specific as possible.

_____
_____
_____

How long has this concerned you? _____, Is it causing pain? Y / N

Have you had any prior treatment(s) for this (circle): Y / N. If YES how and when was this treated? Did it help?

_____

Primary care physician (name, office #): _____, (_____)_____

Referring physician (name, specialty, #): _____, _____, (_____)_____

Preferred Pharmacy Name: _____, #: (_____)_____

Pharmacy Address, City, State: _____, _____, _____

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Medical / Surgical History: Do you or have you ever had any of the following?

- ☐ Diabetes, (circle) Type I / II
- ☐ Thyroid problem (circle): hyper / hypo
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular heartbeat, type: _____
- ☐ Heart attack, date of last: ___/___/_____
- ☐ Heart failure
- ☐ Heart valve problem, valve: _____
- ☐ Stroke / TIA, date of last: ___/___/_____
- ☐ Asthma (circle): mild / moderate / severe
- ☐ Sleep apnea (circle): C-PAP, Bi-PAP, retainer
- ☐ Anemia
- ☐ Blood clots in legs or lungs
- ☐ Easy bleeding / bruising
- ☐ Other blood disorders, type: _____
- ☐ Blood transfusion, date last: ___/___/_____
- ☐ Skin cancer, area: _____
- ☐ Other cancer, type: _____
- ☐ Mammogram, date of last: ___/___/_____
- ☐ Migraine Headaches
- ☐ Seizures
- ☐ Arthritis
- ☐ Colitis / IBD
- ☐ Kidney Problems
- ☐ Back Problems
- ☐ Ear / Eye Problems
- ☐ Stomach Problems
- ☐ Keloid Scarring, area: _____
- ☐ Psychiatric diagnosis: _____
- ☐ Tuberculosis
- ☐ AIDS or HIV positive
- ☐ Hepatitis, Type B / C, Treated? Y / N

List any other medical conditions and any major hospitalizations including dates, within the last 10 years:

_____

_____

List all past surgical procedures cosmetic and otherwise, including dates: _____

_____

_____

If you are here for a face concern, please indicate if you have ever received: BOTOX / Filler / KYBELLA injection,

Area(s) injected: _____, Date injected last: _____

Are you allergic to or have you ever had a reaction to any medication, local anesthetic, or general anesthetic? Y / N

If so, please list the medication(s) and type of reaction:_____

_____

What medications do you take regularly (include all meds / supplements / vitamins, dose, and frequency):

_____

_____

Family History. Please list any diseases or conditions that run in your family and the family member (i.e. father):

_____

_____

Have you or a member of your family ever had a problem with Anesthesia? Y / N

Please explain: _____

_____

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Social History. Marital Status (circle one): Single / Married / Divorced. # of children: _____

Profession: _____, (circle): Working / Retired / Disability

Nicotine Status (circle): Never / Current / Former (year quit) _____. Type: Smoke / Chew / Vape / Patch / Gum

Alcohol Status: _____ drinks per (circle): day / week / month / year. If quit, when: ____/____/_____

(Circle): Marijuana? Y / N. Illicit Drugs: Never / Current / Former (year quit) _____. Type: _____

Review of Symptoms. Indicate if you have had any of the following symptoms in the past 72 hours (circle any):

Fever, chills, sweats, nausea, vomiting, diarrhea, skin / wound infection area: _____

Headache, dizziness, confusion, memory loss, depression, anxiety, suicidal thoughts, thoughts of harming others

Change in vision, blindness, double vision, dry / itchy eyes, excess tearing, eye pain

Nose-bleed, nasal congestion, nasal drip, difficulty breathing through nose, ringing in ears, difficulty hearing

Cough, bloody sputum, wheezing, shortness of breath, chest pain, palpitations, light-headed, pale

Abdominal pain, flank pain, back pain, bloody stools, pain with urination, blood in urine

Arm / leg / face / neck weakness, arm / leg / face / neck pain, arm / leg / face / neck numbness

Skin rash, open wound, new skin lumps or spots, itchy skin area

I certify the above information to be true to the best of my knowledge.

Patient (or Legal Guardian) _____ Date ____/____/_____

Reviewed by Physician _____ Date ____/____/_____

BAY AREA ESTHETICS

Patient Consent to Treatment

Please read each section carefully. Initial the end of each section to acknowledge your understanding and consent.

Patient Name (first last) _____ Date ____/____/_____

I, undersigned, do hereby request and consent to an evaluation and treatment by Bay Area Esthetics Plastic Surgery (the medical practice), and its physicians or other practitioners. I wish to rely on Bay Area Esthetics Plastic Surgery to exercise judgment for my best interest, or that of my dependent (the above-named patient) during their course of treatment. I will inform Bay Area Esthetics Plastic Surgery or its staff who is treating me or my dependent of any medical problems, sensitive areas, or adverse conditions that I or my dependent may have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment. _____

I clearly understand and agree that all services rendered to me or to my dependent, the above-named patient, may be charged directly to me and that I am personally responsible for full payment. I understand that even if I suspend or terminate treatment, any fees for professional services rendered to or reserved for me or to my dependent up to the point of termination will be immediately due and payable. _____

I acknowledge that Bay Area Esthetics Plastic Surgery may not be contracted with my medical insurance company. As such, I agree that I am responsible for any outstanding fees for services provided to me or to my dependent, the above-named patient, charged by Bay Area Esthetics Plastic Surgery that are not reimbursed to them through health insurance or out of network coverage, insurance or other third party payers; this includes all co-payments, deductibles, and out of pocket costs. I understand that a potentially refundable deposit to cover fees for uncovered services may be required prior to or at the time of service. I also understand that I may be responsible for paying a $100.00 No-show fee for missed or late appointments. _____

For cosmetic procedures, I understand that I will be responsible for all facility and anesthesia fees incurred for subsequent revisions and/or emergency procedures performed on me or my dependent, the above-named patient, as well as necessary supplies including but not limited to implants, unless otherwise specified by Bay Area Esthetics Plastic Surgery. Any surgeon's fee that may be incurred for subsequent revisions and/or emergency procedures will be addressed on a case by case basis. In the event that I have a cosmetic insurance policy covering a procedure, I will be responsible for all fees incurred above and beyond the coverage limits of this policy. _____

I authorize Bay Area Esthetics Plastic Surgery to submit all precertification and claims directly to the insurers on my behalf. I hereby authorize the release of my medical records and other information necessary to process insurance claims. I understand and agree that any and all monies received from insurance companies and/or other third party payers as reimbursement for services rendered to me or to my dependent, the abovenamed patient, by Bay Area Esthetics Plastic Surgery and its physicians or practitioners shall be forfeited in full to Bay Area Esthetics Plastic Surgery. Any other arrangements that may involve insurance billing, reimbursement, payment deferral or financing, must be made in writing with the medical practice owner and/or business manager of Bay Area Esthetics Plastic Surgery. Verbal agreements are not acceptable. _____

Patient / Guardian Signature: _____, Name: _____, Date ____/____/_____

Witness Signature: _____, Name: _____, Date ____/____/_____

BAY AREA ESTHETICS

Notice of Privacy Practices Summary

This notice describes how medical information about you may be used and disclosed by Bay Area Esthetics Plastic Surgery, and how you can access this information. Please review it carefully and acknowledge your understanding on the next page.

We understand the importance of privacy and are committed to maintaining the confidentiality of your information. We make a record of the medical care we provide and may request / receive records from other providers or health care institutions. We use this information to provide medical care, or enable other health care providers to provide medical care, to obtain payment for services provided to you, and to meet our professional and legal obligations for operating the medical practice. We are required by law to maintain the privacy of protected health information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. This summary of our Privacy Practices lists how we may use and disclose your PHI. It also lists your rights and our legal obligations with respect to protecting your PHI. If you have any questions about the Notice, please ask to speak with our Privacy Officer or Practice Manager.

A. How our office may use or disclose your health information

We collect health information about you and store it in a chart and/or electronic record. This is your medical record. The law permits us to use or disclose your health information for the following purposes.

1. Medical Treatment
2. Collecting Payment
3. Health Care Operations
4. Appointment Reminders
5. Notification & Communication with Family
6. Required by Law
7. Public Health
8. Health Oversight Activities
9. Judicial and Administrative Proceedings
10. Law Enforcement
11. Coroners
12. Organ & Tissue Donation
13. Public Safety
14. Socialized Government Functions
15. Workers Compensation
16. Change of Practice Ownership

B. When this office may or may not use or disclose your health information except as described in this Notice of Privacy Practices.

This office will not use or disclose health information which identifies you without your written authorization. If you do not authorize this office to use or disclose your health information for any purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to request special privacy protections
2. Right to request confidential communication
3. Right to inspect and copy
4. Right to amend or supplement
5. Right to an accounting of disclosures
6. You have the right to a paper copy of the complete Notice of Privacy Practices

D. Changes to this Notice of Privacy Practices.

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this notice. After an amendment is made, the revised notice will apply to all protected health information that we maintain, regardless of when it was created or received. A copy will be available.

E. Complaints

Complaints about this Notice of Privacy Practices or how this office handles your health information should be directed to the licensed healthcare professional. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to the Department of Health and Human Services.

Effective Date: This notice was published and becomes effective on 06/21/202

BAY AREA ESTHETICS

Written Acknowledgement of Privacy Practices

The Notice of Privacy Practices you read above, provided information about how we may use and disclose Private Healthcare Information about you. As described in the notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

Please acknowledge your understanding of the privacy practices notice by attesting to the statement below.

I have read and/or received a copy of the Notice of Privacy Practices of Bay Area Esthetics Plastic Surgery. I have had an opportunity to read the Notice of Privacy Practices and I understand it fully. I understand that I may ask questions of any physician or staff member of Bay Area Esthetics Plastic Surgery if I were to not comprehend any information contained in the above Notice of Privacy Practices, and have had ample opportunity to do so.

Patient / Guardian Name (first last): _____

Patient / Guardian Signature: _____ Date ____/____/_____