TODAY'S DATE_____

FULL LEGAL NAME_____**DATE OF BIRTH** ____/____/____ **AGE**_____

NICKNAME_____ **M/F**_____

ADDRESS _____

CITY **STATE** **ZIP**

CELL # _____**WORK #**_____**HOME #**_____

SSN_____ **EMAIL ADDRESS**_____

SPOUSE/PARTNER NAME_____**PHONE**_____

EMERGENCY CONTACT_____**PHONE**_____

Height: _____**FT**_____**IN** **Weight:** _____**LBS**

REASON FOR VISIT _____

Would you like to receive information about specials through email? Yes_____**No**_____

INSURANCE INFORMATION:

PRIMARY INSURANCE_____**ID#**_____**GROUP**_____

INSURED'S NAME_____**DATE OF BIRTH**_____ **SSN**_____

INSURED'S EMAIL ADDRESS _____

EMPLOYER_____ **WORK PHONE**_____

SECONDARY INSURANCE_____**ID#**_____**GROUP**_____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

_____**My Physician**_____ **Insurance Provider**_____

_____**A Friend/Family Member**_____ **Washingtonian Magazine** _____

_____**Another Patient**_____**Other**_____

_____**Internet Search**_____

PLEASE CHECK ANY OF THE FOLLOWING THAT INTERESTS YOU:

_____Botox	_____Facial Fillers	_____Skin Rejuvenation
_____Breast Augmentation	_____Breast Reduction	_____Breast Lift
_____Liposuction/Body Contouring	_____Tummy Tuck	_____Thigh/Arm Lift
_____Eyelid surgery	_____Rhinoplasty (nose job)	_____Otoplasty (ear pinning)
_____Facelift/Browlift	_____ Necklift	_____Laser Resurfacing
_____Sun Spots	_____Chemical Peels	_____Hair Removal
_____Scar Management	_____Double Chin (Kybella)	_____Lip Fullness

MEDICAL INFORMATION

For your benefit it is necessary that you answer these questions as accurately as possible so that we can determine your physical condition before undergoing surgery.

PRIMARY PHYSICIAN'S NAME_____**PHONE NUMBER**_____
REFERRING PHYSICIAN'S NAME_____

PAST SURGICAL PROCEDURES W/ DATES, AND COMPLICATIONS – IF ANY:

_____
_____

Current Medications and Supplements:

_____
_____
_____
_____
_____
_____

Sleep Apnea?_____
Latex Allergy? _____

Allergies:

_____
_____
_____
_____

PHARMACY NAME AND NUMBER_____

Do you have or have ever had any of the following?

	YES	NO		YES	NO		YES	NO
Heart disease	___	___	Liver Disease	___	___	Asthma	___	___
High blood pressure	___	___	Dry eye syndrome	___	___	Glaucoma	___	___
Shortness of breath	___	___	Hepatitis	___	___	Chest pain	___	___
Cancer	___	___	Depression	___	___	Diabetes	___	___
Anemia	___	___	Cold sores	___	___	Seizures	___	___
Easy Bruising	___	___	Thyroid disease	___	___	AIDS/HIV	___	___
Kidney Disease	___	___	Nervous Condition	___	___	Bleeding Disorder	___	___

Do you take:	YES	NO		YES	NO		YES	NO
Heart medication	___	___	Blood thinners	___	___	Garlic	___	___
High blood pressure medication	___	___	Aspirin	___	___	Ginseng	___	___
Ginger	___	___	Ginkgo	___	___	Diuretics	___	___
Saint John's wort	___	___	Steroids	___	___	Echinacea	___	___
Testosterone	___	___	Anti-Inflammatories	___	___	(Advil, Ibuprofen)		

Do you smoke? YES NO **Do you drink alcohol**? YES NO
If yes, how much and how often?_____

Have you ever had a problem with drugs or alcohol now or in the past? YES NO

Any additional medical problems that have not been addressed?_____

Patient's Authorization to Release Medical Information/
Claim Payment Authorization

I hereby authorize Dr. Bruno/Brown to release any information regarding services rendered by him and allow a photocopy of my signature to be used to file insurance.

_____ X_____
DATE PATIENT

I agree to present all claims to my health insurance carrier. I understand that I will remain liable for all physician's charges, and in the event of PAST DUE accounts, I understand that collection costs, court costs, and reasonable attorney's fees will apply to all past due accounts. I hereby authorize and direct payment check(s) for benefits due me for the services rendered by Dr. Bruno/Brown to be made directly to him.

_____ X_____
DATE PATIENT

CONSENT TO TAKE AND RELEASE OF PHOTOGRAPHS

The use of Before and After photographs is essential to the planning and evaluation of plastic surgery and are part of your permanent medical record.

- They provide an accurate record of your appearance before surgery
- Should you or your physician decide on further consultations, photographs add scope and clarity to your discussions
- They assist your physician in planning your operation. Accurate medical photographs act as an "instrument" the doctor can work with using overlays, drawings and written indications for guidance.
- In the operating room, your photographs become an integral part of the surgical procedure, serving as an immediate and reliable reference during every step.
- Medical photographs are a reliable visual document to which you and your surgeon can refer at any time.

Your **anonymous** photographs are also essential for use in patient education in the office, at seminars, at medical conferences, and on our website for the purpose of educating prospective patients who are in the process of choosing a plastic surgeon or evaluating specific procedures. All pictures will remain completely anonymous and every effort is made to remove any identifiable features such as tattoos, birthmarks, or jewelry.

CONSENT: I hereby authorize Bruno|Brown Plastic Surgery to take and use pre-operative, intra-operative, and post-operative photographs for professional medical purposes deemed appropriate. This may include, but is not limited to, showing these images for purposes of medical and patient education.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images.

_____ X_____
DATE PATIENT

Acknowledgment of Receipt of General Notice – Form 1

I acknowledge that I was provided with a copy of the General Notice of my rights regarding my medical records.

_____
Name of Patient (printed) Date

_____
Signature of Patient (or Guardian)

General Authorization for Release of Medical records – Form 2

I acknowledge that I was provided with a copy of the General Authorization for Release of Medical Records, and that these policies may be changed by the provider and I will be given an update if this occurs.

_____ _____
Name of Patient (printed) Date

_____ _____
Signature of Patient (or Guardian) Date

_____ _____
Witness Date

DISCLOSURE TO FAMILY/FRIENDS

_____ I do not want Bruno|Brown Plastic Surgery ("Provider") to disclose any information concerning my care or treatment by Provider to individuals without my express written consent or legal authorization.

_____ I authorize Provider to disclose information related to my care and treatment to the following named individual(s):

_____ _____

The authorizations provided for above are subject to the following limitations or restrictions:

_____

_____ _____
Name of Patient (Printed) Signature of Patient (or Guardian) Date

_____ _____
Witness (Printed) Signature of Witness Date