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

I hereby authorize Dr. Bruno/Brown/Tan to release any information regarding services rendered by him/her 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/Tan to be made directly to him/her.

_________________________ X____

DATE PATIENT

CONSENT TO TAKE PHOTOGRAPHS FOR YOUR MEDICAL RECORD

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.

_________________________ X____

DATE PATIENT

CONSENT TO RELEASE PHOTOGRAPHS

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.

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**.

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 Notice to Patients – 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)

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

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