

Stanislaw Facial Plastic Surgery Center LLC

Paul Stanislaw Jr., M.D.

Patient Information

Patient Name _____ Date of Birth _____ Age _____
Social Security # _____ Marital Status S M D W Sex M F
Address _____ Home (_____) _____
City _____ State _____ Zip _____ Cell (_____) _____
Employer _____ Work (_____) _____
Address _____ City _____ State _____ Zip _____
Email: _____

Responsible Party (Complete only if someone other than patient is financially responsible)

Name _____ Relationship to you _____
Social Security # _____ Marital Status S M D W Sex M F
Address _____ Home (_____) _____
City _____ State _____ Zip _____ Cell (_____) _____
Employer _____ Work (_____) _____

Emergency Contact

Name _____ Relationship to you _____
Home (_____) _____ Work (_____) _____

Insurance Information

Primary Insurance _____ ID _____ Group _____
Subscriber _____ Date of Birth _____ Relationship Self Spouse Parent

Secondary Insurance _____ ID _____ Group _____
Subscriber _____ Date of Birth _____ Relationship Self Spouse Parent

Primary Care Physician: _____

Pharmacy: _____ Phone: (_____) _____

Referred By (Check all that apply-use the corresponding space to elaborate)

- Patient _____ Public Seminar _____
- Physician _____ Advertisement _____
- Internet Website _____ Other _____

Interest/Concern (By checking below I am authorizing FPSC to provide information or services)

- Aging Face (Non-surgical) Injectable Fillers Skincare Services/Products
- Aging Face (Surgical) Botox Mineral Make-up
- Rhinoplasty (Nose) Educational Programs/Events
- Other _____

Patient Signature _____ Date _____

NAME: _____ DATE: _____

DATE OF BIRTH: _____

Who is your Primary Care Physician? _____

Who is your Dermatologist / Esthetician? _____

Have **YOU** or any *RELATIVES* had problems with any of the following conditions?

	<u>MYSELF</u>		<u>RELATIVE</u>		<u>(What relationship?)</u>
	Yes	No	Yes	No	_____
Heart disease	Yes	No	Yes	No	_____
High Blood Pressure	Yes	No	Yes	No	_____
Diabetes	Yes	No	Yes	No	_____
Stroke	Yes	No	Yes	No	_____
Excessive Bleeding	Yes	No	Yes	No	_____
Excessive Bruising	Yes	No	Yes	No	_____
Poor healing	Yes	No	Yes	No	_____
Excessive Scarring	Yes	No	Yes	No	_____
Cancer	Yes	No	Yes	No	_____
Skin Cancer	Yes	No	Yes	No	_____
Glaucoma	Yes	No	Yes	No	_____

Please Explain any "Yes" answer here: _____

Do you have a history of sunburns in childhood?	YES	NO
Do you have a heart murmur?	YES	NO
Do you have any artificial joints?	YES	NO
Do you have chest pain or pressure?	YES	NO
Do you have high cholesterol?	YES	NO
Do you have asthma or lung problems?	YES	NO
Do you have seasonal or environmental allergies?	YES	NO
Do you have any thyroid problems?	YES	NO
Do you have liver problems?	YES	NO
Have you ever had hepatitis? Type A , B, or C ?	YES	NO
Have you ever had a seizure or convulsions?	YES	NO
Do you have problems with your eyes (besides glasses)?	YES	NO
Is any part of your body paralyzed or numb?	YES	NO
Do you have any kidney problems?	YES	NO
Do you have anemia or any problems with your blood?	YES	NO
Have you ever had a blood transfusion?	YES	NO
Have you ever had cold sores, or fever blisters?	YES	NO
Do you have a history of dry eyes?	YES	NO
Women:		
Are you, or could you be pregnant?	YES	NO
Are you breast feeding?	YES	NO
Do you wear hearing aids?	YES	NO
Have you been diagnosed with MRSA?	YES	NO

NAME: _____ DATE: _____
DATE OF BIRTH: _____

Please list any other medical problems that have not been covered _____

Please list all past surgeries / operations: _____

Do you take any medications, including birth control pills or aspirin? YES NO
Please list: _____

Do you take vitamins, over the counter medications, or herbal supplements? YES NO
Please list: _____

Have you taken steroid medication in the last year? YES NO
Have you ever taken the medication Accutane? YES NO
Are you allergic to any medications? YES NO
If yes, what medication and what was the reaction? _____

Do you have a sensitivity / allergy to latex? YES NO
Do you have a sensitivity / allergy to tape? YES NO

Do you smoke? How Much? _____ YES NO
Do you use recreational drugs? YES NO
Do you drink alcohol? How much? _____ YES NO

Consent for Release of Information/Assignment of Benefits

I authorize Paul Stanislaw, Jr., MD to release any information pertaining to my diagnosis and treatment to my Primary Care Physician(s).

I understand that I have insurance coverage and authorize payment of medical benefits to Paul Stanislaw, Jr., MD for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the release of any medical information necessary to process the claim and secure payment of benefits.

Signed: _____ **Date:** _____
PATIENT SIGNATURE

The above information was reviewed and confirmed with the patient.

Signed: _____ **Date:** _____
PAUL STANISLAW, JR., MD., FACS

Acknowledgement of Receipt of Notice of Privacy Practices

Dr Paul Stanislaw, Jr., M.D.
Kristen Marino, Licensed Esthetician
Julie Brookman, Licensed Esthetician

Stanislaw Facial Plastic Surgery Center, LLC
35 Nod Road, Suite 204
Avon, Connecticut 06001

Privacy Officer: Debra Kehoe, Office Manager, (860) 409-1515

Name of Patient: _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices.

Signed: _____ Date: _____

If signed by other than patient, please indicate your relationship to the patient:

For Office Use Only:

Acknowledgment refused:

Efforts to obtain: _____

Reasons for refusal: _____

Received By: _____ Date: _____