Stanislaw Facial Plastic Surgery Center LLC

Paul Stanislaw Jr., M.D.

Patient Information

Patient Name _____ Date of Birth _____ Age _____

Address_____ Marital Status _____ Sex _____

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 _____

Address_____ Marital Status _____ Sex _____

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?

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

Please Explain any "Yes" answer here:_____
_____
_____
_____

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

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? ☐ ☐
Please list: _____
_____
_____
_____
Do you take vitamins, over the counter medications, or herbal supplements? ☐ ☐
Please list: _____
_____
_____

Have you taken steroid medication in the last year?	☐	☐
Have you ever taken the medication Accutane?	☐	☐
Are you allergic to any medications?	☐	☐

If yes, what medication and what was the reaction? _____
_____
_____

Do you have a sensitivity / allergy to latex?	☐	☐
Do you have a sensitivity / allergy to tape?	☐	☐

Do you smoke? How Much? _____	☐	☐
Do you use recreational drugs?	☐	☐
Do you drink alcohol? How much? _____	☐	☐

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: _____

STANISLAW FACIAL PLASTIC SURGERY CENTER

Due to the nature of our practice, confidentiality is paramount to our patients. As medical practitioners, we highly respect your privacy. In fact, we are legally and ethically bound to protect your personal information. We can also appreciate your need to be informed of special promotions, events and medical updates.

The intent of this consent is to determine your preference for marketing communications. If you prefer not to receive marketing communications please select Opt Out. **You can also choose to receive your notifications by mail, email or both by selecting Opt In to each**. Please be advised that we may not necessarily send notifications by both methods of communications. Specials and events are also available on our website at www.StanislawMD.com.

ABOUT EMAIL NOTIFICATIONS

Many of our patients have requested communications through email as a more private means of relaying information as opposed to mail or discussions on the telephone while at work. As a general rule, it is a great means of communication to relay information regarding specials and events. It is important to realize however that email is not a secure means of communications since it is not encrypted. Any personal health information should be avoided or limited when using email. If you wish to contact our office through email we can be reached at info@StanislawMD.com. Your email will be answered during normal business hours Monday through Friday.

Email is an excellent choice for communications because it is a private, cost-effective and an eco-friendly way to deliver information when used responsibly. Our office will be limiting email communications to ensure you only receive appropriate and periodic emails which will include Quarterly Specials, Seminars or Events. At any point should you choose to Opt Out of email communications, you can select "Unsubscribe" in the body of the email you receive. Please DO NOT select SPAM since that adversely affects our practice. You can also call our office at (860) 409-1515 and we will IMMEDIATELY take you off our list. **We will NEVER share your email address with ANYONE.**

YOU MAY CHOOSE TO OPT OUT OR CHANGE YOUR PREFERENCE AT ANY TIME

☐ EMAIL OPT IN _____. _____

Please PRINT LEGIBLE email address above

☐ MAIL OPT IN _____

Mailing Address

_____

City, State, Zip code

☐ OPT OUT I do NOT wish to receive any promotional communications.

_____ _____

Signature Date

Please return this completed form to

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

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Mailing Address

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