# Vargas Face & Skin Center New Patient Forms Today's Date: _____

## PATIENT INFORMATION

Name | Date of Birth

Address | Age

City | State | Zip | Weight | BMI

Home # | Height

Cell # | Cell Carrier: | Status M S D W

Please TEXT me w/ Appt Reminders: YES NO | Gender M F

Please EMAIL me w/ Appt Reminders: YES NO

Email:

Occupation | Work #

Primary Care Physician | Physician's #

Pharmacy you use | Pharmacy #

## How Did You Hear About Vargas Face and Skin Center / Reason For Seeing Dr. Vargas

Vargas Website _____

Television _____

Realself.com _____

Google/Internet Search _____

Dr. Referral / List the Physician:

Patient Referral / List the Patient:

Other:

Have you consulted with other Plastic Surgeons?

How long have you considered plastic surgery or the procedure you are here for today?

Why are you interested in plastic surgery or other procedures?

Have you had previous procedures? Please list.

Please tell us the reason for your visit today?

| | | | |
|---|---|---|---|
| Botox | Consult - Aging Face | Consult - Face Lift | Laser Resurfacing |
| Fillers | Consult - Chin | Consult - Neck | Acne / Skin Care |
| Liposuction | Consult - Ears | Consult - Nose | BBL / SkinTyte |
| Scars | Consult - Eyes | Hair Restoration | Facial Services |

Other:

## Emergency Contact Information

Name | Contact # Cell or Home | Relationship

## Allergies and Sensitivities

Are you allergic to any medications or anesthesia? NO YES

**If YES, please explain.**

## Family History

Please list any diseases that run in your family.

Have any of your relatives had anesthesia complications?

**If YES, Please Explain.**

## Social History

| | | | | |
|---|---|---|---|---|
| Do you SMOKE? | NO | YES | How Much? | |
| Do you DRINK? | NO | YES | How Much? | |
| Do you have CHILDREN? | NO | YES | How Many? | |

## Specific Medical History

| | | | |
|---|---|---|---|
| Are you currently nursing? | NO | YES | Explain |
| Are you currently Pregnant? | NO | YES | How Far? |
| Asthma or Emphysema? | NO | YES | Explain |
| Do you have high cholesterol? | NO | YES | Explain |
| High Blood Pressure? Concerning | NO | YES | Explain |
| Rashes/Moles? Kidney | NO | YES | Explain |
| Trouble/Diabetes | NO | YES | Explain |
| Panic or Depression? | NO | YES | Explain |
| Stomach ulcers/reflux? | NO | YES | Explain |
| Heart Trouble? | NO | YES | Explain |
| History of Stroke? | NO | YES | Explain |
| Problem scarring/bruising? | NO | YES | Explain |
| Hepatitis / Liver Disease | NO | YES | Explain |
| Thyroid Disease | NO | YES | Explain |
| HIV | NO | YES | Explain |
| Have you been advised to have, or have you had Psychiatric care in the past? | NO | YES | Explain |

List any others not shown above:

## Medications / Herbals / Vitamins

List ***ALL MEDICATIONS*** you are taking:

| | | | |
|---|---|---|---|
| Do you take any **HERBALS?** | YES | NO | LIST any taking: |
| Do you take any **ASPIRIN?** | YES | NO | Notes: |
| Do you take **VITAMINS?** | YES | NO | LIST any taking: |

Do you take any **NSAIDS / Ibuprofen / Advil?** YES NO

## Past Surgeries

Please list ALL SURGERIES, and approximate SURGERY DATES, you have had in the past:

## Hair History

Reviewed by HV: _____ _____ _____ _____ _____

# HIPPA Information and Consent Form

Patient Name: _____ Date: _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

We have adopted the following policies:

Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

We agree to provide patients with access to their records in accordance with state and federal laws.

We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

## Consent to Communicate

In the interest of facilitating care, I give permission to my doctor and staff to communicate with me, my designated care team, each other, and other health care providers about my care via telephone, e-mail, U.S. mail, text, fax, and internet which are non-secured forms of communication.

I,_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form, Consent to Communicate, and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

## Photo Consent - Post Operative Consent for Photo Use

By allowing Vargas Face and Skin Center to use your before and after photos and/or video, you are helping other patients to visualize their goals. This helps to ease the minds of those who need to see other results prior to making their decision to have cosmetic surgery or a cosmetic procedure completed. At Vargas Face and Skin Center, we appreciate that you may allow us to share your before and after photos, and also understand if you do not feel comfortable in doing so. No compensation of any kind is given to patients who do allow their photos to be used.

I, **<PersonalInfo.FullName>** give my consent to Vargas Face and Skin Center to **use** my before and after photos and/or video. The photos and/or video may be used for teaching, scientific research/publication, in-office and on the web.

**Patient Acceptance:**
I **<PersonalInfo.FullName>** have read the photo consent section and I understand and agree.

| Signature-Patient or Guardian | Print Name | Date |
|---|---|---|

| VFSC Witness | Date |
|---|---|