HEDGEWOOD PLASTIC SURGERY
FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY
THOMAS H. M. MOULTHROP, M.D., F.A.C.S
CHRISTIAN D. JACOB, M.D.
2427 SAINT CHARLES AVENUE ● NEW ORLEANS, LOUISIANA 70130 ● (504) 895-7642

Date: _____

Patient Name: _____
First *Middle* *Last*

Date of Birth: _____ Age: _____ Sex: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Email Address: _____

Employer Name: _____

Occupation: _____ Work Phone: ( ) _____

What pharmacy do you use?_____ Phone: ( ) _____

Pharmacy Address: _____

REASON FOR VISIT

What area(s) of the face or neck are you interested in having improved?

☐ Neck/Jowls/Jawline ☐ Eyes/Brow ☐ Nose ☐ Chin ☐ Ears

☐ Lips/Injectables ☐ Skin/Wrinkles ☐ Other: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

☐ I am a former patient of Calvin M. Johnson, Jr., M.D.
☐ Event
☐ Internet search
☐ Other: _____

☐ Patient Referral: _____
☐ Friend: _____
☐ Dr. Referral: _____

May we send a referral thank you? ☐ YES ☐ NO

EMERGENCY CONTACT

Name: _____

☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Home phone: _____ Cell phone: _____ Work phone: _____

HEDGEWOOD PLASTIC SURGERY
Consent to Communicate

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)
☐ Call Work Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐
☐ Call Cell Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐
☐ Call Home Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐
☐ Send Email			☐
☐ Send Text			☐

If it's ok to leave a message with another person, please list below:

Name	DOB	Relationship	Ok to Release Results	Any Comments:
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Signature Date

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Medical Evaluation

Patient Name: _____ Date: _____

Height: _____ Weight: _____

Primary care physician: _____

How is your general health? _____

When was your last physical examination? _____

MEDICAL ISSUES

- ☐ Abnormal Bleeding
- ☐ Asthma/Lung Disease
- ☐ Autoimmune Disease
- ☐ Blood Clots/DVT/PE
- ☐ Diabetes
- ☐ Fever Blisters/Herpes
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Liver/Kidney Disease
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Unusual scarring/Keloids
- ☐ Heart Disease-
  - ☐ Arrhythmias
  - ☐ Chest Pain
  - ☐ Pacemaker
  - ☐ Stents

PAST SURGICAL HISTORY

Have you undergone general anesthesia ("been put to sleep")? ☐ YES ☐ NO

Have you or a family member had an unusual reaction, such as nausea or vomiting, to anesthesia? ☐ YES ☐ NO

Describe: _____

Please list all surgeries (major or minor):

_____

_____

_____

ALLERGIES/SENSITIVITIES

Are you allergic to latex? ☐ YES ☐ NO

Are you allergic to tape? ☐ YES ☐ NO

Are you allergic to any medications? ☐ YES ☐ NO

Drug/Reaction: _____

_____

MEDICATIONS

Please list both prescribed and over-the-counter, including inhalers, eye drops, vitamins, and supplements:

_____

_____

_____

_____

_____

Do you take aspirin? ☐ YES ☐ NO *Frequency taken:* _____

Do you take ibuprofen (Advil/Motrin/Nuprin)? ☐ YES ☐ NO *Frequency taken:* _____

EYES

Dry eyes or use drops regularly? ☐ YES ☐ NO

Recent visual exam? ☐ YES ☐ NO

Eye or eyelid surgery? ☐ YES ☐ NO *If yes, what type?* _____

NOSE

Difficulty breathing through nose? ☐ YES ☐ NO

Prior trauma to nose? ☐ YES ☐ NO

Sinus or nasal surgery? ☐ YES ☐ NO *If yes, when/where?* _____

FACE

Previous face or neck surgery? ☐ YES ☐ NO

Radiation therapy to head or neck? ☐ YES ☐ NO

Facial paralysis or weakness? ☐ YES ☐ NO

Laser resurfacing or chemical peel? ☐ YES ☐ NO

Rosacea or highly sensitive skin? ☐ YES ☐ NO

SKIN CARE

Are you receiving any Injectables, such as Botox or fillers? ☐ YES ☐ NO

By whom? _____

Do you have a physician recommended skin care program? ☐ YES ☐ NO

Describe: _____

Who/where is your regular stylist or salon? _____

SOCIAL HISTORY

Have you used any nicotine products (gum, vaporizer, patch) or tobacco in the past year? ☐ YES ☐ NO

Do you have more than two alcoholic beverages per day? ☐ YES ☐ NO

Have you been treated for any drug or alcohol dependency? ☐ YES ☐ NO

Have you ever received psychiatric treatment? ☐ YES ☐ NO

Is there any reason you may be at risk for HIV/AIDS? ☐ YES ☐ NO

Have you had any recent crises in your life? ☐ YES ☐ NO

_____

Signature Date

HEDGEWOOD PLASTIC SURGERY
HIPAA Information and Consent Form

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. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. 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.

2. 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.

3. 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.

4. 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.

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

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

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

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

9. 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.

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

Signature: _____ Date: _____