PATIENT INFORMATION

Date: ___________________________________

Name: [First] ______________________ [M.I.] _____ [Last] ______________________________ □ Male | □ Female

Address: ____ [Apt.] __________ Age: _________ D.O.B: ________________

City: _________________________________ State: ________ Zip: _____________ Social Security #: __________________

Home Tel: _____________________ Mobile Tel: _________________________Work Tel: _________________________

E-mail: ____ Marital Status: □ Single |□ Married |□Other ________

SPOUSE CONTACT [If Applicable]

Name: [First] _______________________ [Last] _______________________ Spouse's Mobile Tel: ________________

Spouse's Employer: ____ Spouse's Work Tel: _________________

EMPLOYMENT INFORMATION: □ Full Time | □ Part Time | □ Student | □ Retired | □ Other Occupation: ______________

Employer/School: ____ Work Tel: ___________________________

Work/School Address: ______________________________ City: ______________________ State: ______ Zip: ________

EMERGENCY CONTACT

Name: [First] _______________________ [Last] _______________________ Home Tel: _________________________

Relationship to Patient: ____ Work Tel: ___________________________

Address: ______________________________ City: ______________________ Mobile Tel: ________________________

State: ______ Zip: ______________

Permission to disclose information to persons involved in my healthcare:

_______________________________________ _____________________________________

Name **Relationship**

_______________________________________ _____________________________________

Name **Relationship**

REFERRAL INFORMATION

Referring Physician/Patient/Source: ____

How did you hear about Dr. Becker? ____

Have you been to our website [www.beckermd.com]? □ Yes | □ No

If yes, was our website helpful? □ Yes | □ No

If No, please list reason: ____

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MEDICAL INSURANCE INFORMATION

Primary Insurance Company Name: _________________________________ Telephone: ________________________

Name of Insured: [First] _______________________ [Last] ______________________________

Policy #: __________________ Group #: _________________ Co-pay? □ Yes |□ No If Yes, Amount: $__________

Secondary Insurance Company Name: _______________________________ Telephone: ________________________

Name of Insured: [First] _______________________ [Last] ______________________________

Policy #: __________________ Group #: _________________ Co-pay? □ Yes |□ No If Yes, Amount: $__________

I understand that office visit charges are payable on the day service is rendered. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Becker and myself.

Signature: (Patient, Parent or Guardian) ____ Date: ________________

PHYSICIAN INFORMATION

Primary Care Physician: __________________________ Phone#: ____________________ Fax: ______________________

Cardiologist: ___________________________________Phone #: ____________________ Fax: ______________________

Specialist: _____________________________________Phone #: ____________________ Fax: _____________________

PROCEDURE INFORMATION

What is the reason for your visit today? [Check all applicable procedures below]

FACE: □ Facelift □ Neck Lift □ Brow Lift □ Fat Injections □ Neck Lift □ Fat Grafting to Face □ Upper Eyelid

BREAST: □ Breast Augmentation □ Breast Lift (Mastopexy) □ Breast Revision □ Breast Reconstruction

□ Fat Injections □ Breast Reduction □Capsular Contracture

BODY: □ Liposuction □ Tummy Tuck □ Mommy Makeover □ Body Lift

SKIN: □ Botox / Dysport / Xeomin □ Cosmetic Facial Fillers

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PERSONAL MEDICAL HISTORY

Age: ________________________ Weight: __________________ Height: ___________________

FAMILY HISTORY

Do you have a family history of any medical problems? □ Yes □ No

If yes, please explain? ____

____

SURGICAL HISTORY (please list all surgeries with dates)

□ Never had surgery

____

____

____

____

____

____

Please list **ALL allergies** and describe reactions: ____

____

____

Please list **ALL CURRENT** medications and/or dietary supplements including:

(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins, and Herbal Supplements)

1. ____ 6. ____

2. ____ 7. ____

3. ____ 8. ____

4. ____ 9. ____

5. ____ 10. ____

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CARDIOVASCULAR		NEUROLOGICAL	
High Blood Pressure	□ Yes □ No	Stroke	□ Yes □ No
Heart Attack	□ Yes □ No	Seizures	□ Yes □ No
Angina/ Chest pain	□ Yes □ No	Fainting	□ Yes □ No
Heart Bypass surgery	□ Yes □ No	Dizziness	□ Yes □ No
Stents	□ Yes □ No	Headaches	□ Yes □ No
Pacemaker	□ Yes □ No	**CHRONIC PAIN**	
Defibrillator	□ Yes □ No	Sciatica	□ Yes □ No
Heart Failure	□ Yes □ No	Herniated Discs	□ Yes □ No
Irregular Heartbeat	□ Yes □ No	Neuropathy	□ Yes □ No
Heart Murmur	□ Yes □ No	Lower back pain	□ Yes □ No
ENDOCRINE		Neck pain	□ Yes □ No
Breast Cancer Right Left Bilateral	□ Yes □ No	Difficulty moving neck/head	□ Yes □ No
Diabetes **TYPE 1 TYPE 2**	□ Yes □ No	Cane / walker to ambulate	□ Yes □ No
Hypo or Hyper thyroid	□ Yes □ No	**GASTROINTESTINAL**	
Hypoglycemia	□ Yes □ No	Gallstones	□ Yes □ No
High Cholesterol	□ Yes □ No	Liver	□ Yes □ No
RESPIRATORY		Kidney	□ Yes □ No
Asthma	□ Yes □ No	Ulcers	□ Yes □ No
Bronchitis	□ Yes □ No	Hernias	□ Yes □ No
Emphysema	□ Yes □ No	Heartburn	□ Yes □ No
COPD	□ Yes □ No	Reflux	□ Yes □ No
Shortness of Breath	□ Yes □ No	Irritable Bowel Syndrome	□ Yes □ No
Cough	□ Yes □ No	**SKIN**	
Cough with sputum	□ Yes □ No	Cancer	□ Yes □ No
Sleep apnea	□ Yes □ No	Radiation	□ Yes □ No
CPAP Machine at Night	□ Yes □ No	Scleroderma	□ Yes □ No
PSYCHIATRIC		Psoriasis	□ Yes □ No
Depression	□ Yes □ No	Eczema	□ Yes □ No
Anxiety	□ Yes □ No	**HEMATOLOGY**	
Psychiatric Care	□ Yes □ No	Anemia	□ Yes □ No
Obsessive Compulsive Dis.	□ Yes □ No	Clotting Disorder	□ Yes □ No
Bipolar	□ Yes □ No	Sickle Cell	□ Yes □ No
Schizophrenia	□ Yes □ No	Blood Clots	□ Yes □ No
Auto Immune		Easily Bruise	□ Yes □ No
Lupus	□ Yes □ No	**Other**	
Lyme Disease	□ Yes □ No	Cold Sores	□ Yes □ No
Multiple Sclerosis	□ Yes □ No	HIV-AIDS	□ Yes □ No
Vasculitis	□ Yes □ No	Hepatitis Type:	□ Yes □ No
Rheumatoid Arthritis	□ Yes □ No	Hearing Loss or Aid	□ Yes □ No
Celiac Disease	□ Yes □ No	Deafness	□ Yes □ No
Hashimoto	□ Yes □ No	Memory Issues	□ Yes □ No

Have you had Corona Virus? □ Yes □ No **Have you been Vaccinated for the corona Virus?** □ Yes □ No

Please list any other medical conditions that are NOT listed above: ______________________________

____

____

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Do you use Aspirin or NSAIDs drugs? □ Yes | □ No

Are you on Blood Thinners? □ Yes | □ No

If Yes, medication name: ____

Have you used Diet Pills in the last two (2) weeks? □ Yes | □ No

If Yes, medication name: ____

Have you taken Steroids / Accutane within the last year? □ Yes | □ No

If Yes, medication name: ____

Have you ever smoked tobacco/Hookah/Vape products? □ Yes | □ No

If Yes, # of packs per day: _________________________ # of years: _______________________

If you quit, when? ____

Do you use Recreational Drugs? □ Yes | □ No

If Yes, list type: ____

Do you drink Alcohol? □ Yes | □ No

If Yes, how often: ____

FEMALE QUESTIONNARE

Have you had had any previous pregnancies? □ Yes | □ No o Natural Delivery □ C-Section Delivery

Total pregnancies: _________________ Date of pregnancies: ______________________

Average weight gain during pregnancy: __________________

Did you breast fed after pregnancy? □ Yes | □ No

Do you plan on having any or any more children? □ Yes | □ No

Previous breast mass, suspicious biopsy, or cancer? □ Yes | □ No

Do you have a family history of breast cancer? □ Yes | □ No

Have you had a Mammogram, Ultrasound, MRI in the last year? □ Yes | □ No □ Normal □ Abnormal

If Yes, date of exam: _____________________________________

Current bra size? ____________________________

_______________________________	____	________________
Signature Patient/Parent/Conservator/Guardian	Print Name	Date

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NOTICE OF PRIVACY PRACTICES

At the practice of Hilton Becker, M.D. Aesthetic Plastic Surgery, your privacy is a very important part of our mission and confidentiality is a very big factor in your experience. Dr. Becker and his staff adhere to the highest standards of respecting and protecting patient privacy and the confidentiality of your health care information. Additionally, the team complies with all state and federal regulations regarding the privacy of individual health care information, including HIPPA (Health Care Insurance Privacy and Protection Act), enacted on April 14, 2003.
As of April 14th, 2003, we are required by law to offer you a copy of the "Notice of Privacy Practices" regarding your Personal Health Information (PHI).
Your PHI, also known as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and the nation
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

The "Notice of Privacy Practices" details the following:

- How we may use/disclose your PHI to carry out treatment, payment or health care operations.
- How you may request copies of your healthcare information.
- How you may verify the accuracy of this information.
- How you may request an accounting of certain external disclosures of your PHI.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax, email, mail, or phone.
Please acknowledge that you have been offered a "Notice of Privacy Practices" by signing below:
"I have been offered a Notice of Privacy Practices by the office of Hilton Becker, M.D. Aesthetic Plastic Surgery and I fully understand and accept the terms of this consent."

Print Name: ____

Patient Signature: ____

Date: _________________________

AUTHORIZATION FOR EXAMINATION AND TREATMENT

I,____attest that I am 18 years of ager older, if not, am accompanied by a legal guardian over the age of 18. I hereby consent to and authorize examination and treatment by Dr. Hilton Becker and his medical staff. In the event of any litigation arising from treatment, I agree to submit the case to arbitration. I understand that photography is a necessary part of planning and evaluation a cosmetic or reconstructive surgery. I authorize the taking of photographs at the direction of Dr. Hilton Becker or medical staff. The photographs will be used for documentation and informational purpose.

SIGNATURE OF RESPONSIBLE PARTY: ____

ASSIGMENT AND RELEASE OF INSURANCE INFORMATION: I understand that I am financially responsible for all charges, whether or not covered by my insurance company. I authorize release of my medical records to the insurance company or responsible party for billing purposes. I authorize the insurance company or responsible party to pay directly to Dr. Hilton Becker for and in consideration of services rendered. The undersigned jointly and severely obligates themselves for the payment of all services rendered by Dr. Hilton Becker and his staff. The undersigned hereby acknowledge that I, we are financially responsible for any health insurance deductible, co- insurance, RNFA fee, or failure for any reason of any insurance carrier to pay Dr. Becker's charges, which medical charges together will all court costs, private process fees, collection costs and attorney's fees. I certify that the information I have reported with regards to my insurance coverage is accurate and up to date. SIGNATURE OF

RESPONSIBLE PARTY: ____