beckerMD

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: _____

beckerMD

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: _____

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 Eyelids □ Rhinoplasty □ Other: _____

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

□ Fat Injections □ Breast Implant Exchange □ Breast Reduction □ Breast Asymmetry Correction □ Male Breast Surgery

□ Other: _____

BODY: □ Liposuction □ Tummy Tuck □ Mommy Makeover □ Body Lift □ Buttock Augmentation □ Arm Lift □ Thigh Lift

□ Other: _____

SKIN: □ Botox / Dysport / Xeomin □ Cosmetic Facial Fillers □ Laser □ Other: _____

Have you consulted with other physicians about procedure(s) indicated above? □ Yes | □ No

Is this procedure a revision from a previous surgery? □ Yes | □ No

If Yes, how many previous surgeries? _____

SURGERY SCHEDULING QUESTIONAIRE

To help us understand your needs and time preferences for your surgery, please provide us with the following information:

What is your time preference for your Procedure?

Within the next: □ 1 Month | □ 3 Months | □ 6 Months | □ 1 Year

beckerMD

PHYSICIAN INFORMATION

Primary Care Physician: _____ Phone#: _____ Fax: _____

Cardiologist: _____Phone #: _____ Fax: _____

Specialist: _____Phone #: _____ Fax: _____

PERSONAL MEDICAL HISTORY

Age: _____ Weight: _____ Height: _____ BMI: _____

Do you have any chronic medical problems? [Check off those that apply]

o Anxiety
o Asthma / COPD
o Autoimmune *Type: _____
o Bleeding Problems
o Blood Clot
o Cancer *Type: _____
o Chest Pain
o Chronic pain
o Cold Sores
o Depression
o Diabetes
o Emphysema
o Fainting
o Gastric Reflux
o Gout
o Hearing Aids
o Heart Attack
o Heart Attack
o Heart Disease
o Heart Failure
o Heart murmur
o Hepatitis *Type: _____
o High Blood Pressure
o HIV or AIDS
o Insomnia
o Kidney Disease
o Liver Disease
o Memory Problems
o Neuropathy
o Pacemaker / Defibrillator
o Psychiatric Diagnosis
o Seizures
o Sleep apnea
o Stomach Problems
o Stroke
o Swollen hands and/or feet

Is there a personal or family of *anesthetic complications* or *malignant hyperthermia*? o Yes | o No

If yes, please explain? _____

Have you had Corona Virus o Yes | o No **Have you had the vaccine o Yes | o No**

FAMILY HISTORY

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

If yes, please explain? _____

SURGICAL HISTORY (please list all surgeries with dates)

□ Never had surgery

_____

_____

_____

_____

_____

_____

beckerMD

Please list **ALL allergies** and describe reactions: (i.e. Shellfish, Latex, Penicillin, etc.) _____

_____

_____

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. _____

SOCIAL HISTORY

Do you use Aspirin or medications containing Aspirin? o Yes | o No

Do you use Blood Thinners? (i.e. Coumadin, Heparin, Aspirin or Ibuprofen) o Yes | o No

If Yes, medication name: _____

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

If Yes, medication name: _____

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

If Yes, medication name: _____

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

If Yes, # of packs per day: _____ # of years: _____

If you quit, when? _____

Do you use Recreational Drugs? o Yes | o No

If Yes, list type: _____

Do you drink Alcohol? o Yes | o No

If Yes, how often: _____

Do you have caps, bridges, dentures, or loose teeth? o Yes | o No

If Yes, please explain: _____

REVIEW OF SYSTEMS

Please answer the following Yes or No questions to the best of your ability.
Do you have any of the following conditions, illnesses or symptoms?

CARDIOVASCULAR		**NEUROLOGICAL**	

beckerMD

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
Hypothyroid or Hyperthyroid	□ Yes □ No	**GASTROINTESTINAL**	
Hypoglycemia	□ Yes □ No	Gallstones	□ Yes □ No
High Cholesterol	□ Yes □ No	Cirrhosis	□ Yes □ No
RESPIRATORY		Hepatitis Type:	□ 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	**EYES / EARS**	
Lyme Disease	□ Yes □ No	Glaucoma	□ Yes □ No
Multiple Sclerosis	□ Yes □ No	Cataracts	□ Yes □ No

Vasculitis	□ Yes □ No	Macular Degeneration	□ Yes □ No
Rheumatoid arthritis	□ Yes □ No	Dry Eyes	□ Yes □ No
Celiac Disease	□ Yes □ No	Deafness	□ Yes □ No
Hashimoto	□ Yes □ No	Blindness	□ Yes □ No

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

_____

_____

Have you had blood drawn in the past 3 months? o Yes | o No If Yes, Location: _____

Have you had an EKG done in the last year? o Yes | o No If Yes, Location: _____

Have you had a chest x-ray done in the last year? o Yes | o No If Yes, Location: _____

Have you had a recent Physical Exam? o Yes | o No If Yes, Doctor's Name: _____

Doctor's Phone Number: _____

FEMALE QUESTIONNARE

Female Gynecological History:

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

Total pregnancies: _____ Date of pregnancies: _____

Average weight gain during pregnancy: _____

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

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

Female Breast History:

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

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

Have you had a mammogram in the last year? o Yes | o No Mammogram: o Normal o Abnormal

If Yes, date of exam: _____/_____/_____

Current bra size? _____

Thank you for providing this important information!

_____ _____ _____/_____/_____

Signature Print Name Date

Patient/Parent/Conservator/Guardian
(Indicate if completed other than Patient)

Comments:

_____

_____

Reviewed by: _____ Date: _____

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: _____

beckerMD

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: _____