ELITE
FACIAL PLASTIC SURGERY

Dominic M. Castellano, MD
3000 Medical Park Dr., Suite 210
Tampa, Florida 33613
(813) 975-3223

Patient Information

Patient Name_____**Date**_____

Soc. Sec # _____-_____-_____ **Driver license #**_____

Birthdate:_____/_____/_____ **Age:**_____ **Sex:**_____ **Marital Status:**_____ **Race:**_____

Home Phone # (_____)_____-_____ **Work#** (_____)_____-_____ **Ext:**_____
(May we contact you at work?) yes no

Cell Phone # (_____)_____-_____

E- Mail : _____

Best Contact Method: (__) *Cell* (__) *Home* (__) *Work* (__) *Email* (__) *Mail*

Local Address:_____

City_____ **State**_____ **Zip**_____

Is this your permanent address? Yes No If no, please list alternate address below:

Alternate Address:_____

City_____**State**_____**Zip**_____

Patient Employer:_____**Occupation** _____

Spouse's Name:_____**Phone:**_____

In case of an emergency, please list a LOCAL family member, neighbor, friend, we may contact

(*Please list someone other than your spouse listed above)*_____

Relation:_____ **Phone:** (_____)_____

How were you referred to our office?
(___) Google
Search Term_____ **(___) Attended a Seminar**
(___) www.EliteTampa.com **Where:** _____
(___) Doctor (name) _____ **When:**_____
(___) Friend (name) _____
(___) Email Promotion_____ **(___) Other** _____
(___) Newspaper (section/date)_____
(___) Mailer _____
(___) Billboard_____

For your convenience, we accept all major credit cards, Care Credit, and certified checks. We do not accept personal checks.

Patients Signature:_____**Date:** _____

Cosmetic Health History

Name: _____ **Date**: _____

Age:_____ **Weight:**_____ **Height**____ **Date of Last Physical:**_____

Name of Your Primary Care Physician:_____

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

Office Phone Number_____ **Pharmacy Phone Number**_____

Areas of Concern:

_____

_____

Type of Procedure Considering:

_____

Past Medical History: Do You Have a History of Any of the Following:

_____Heart Disease	_____Hypertension	_____Diabetes
_____Asthma	_____Seizures	_____Hepatitis
_____Hypo/Hyper Thyroid	_____Heart Murmur	_____Rheumatic Fever
_____HIV/AIDS	_____Malignant Hyperthermia	_____Cancer
_____Myasthenia Gravis	_____Cold Sore/Fever Blisters	_____Other, Specify

List any Previous Surgery or Hospitalizations with Approximate Dates:

Current Medications: Please List All Medications you are Taking Prescribed or over-the-counter and the condition for which you take the medications :

_____

Do you have any Drug Allergies: (circle) Yes No

Allergies: Please List any Allergies or reactions to Any Medication, Drugs, Soaps, Solutions, Food, or Latex, and the reaction you experienced :

If you are currently experiencing any pain, describe below the location and current treatment, and rate your pain on 1-10 scale (10= most severe)

_____

Signature of Patient:_____ Date:_____

Cosmetic Health History

Social History:

Do You Smoke: (circle) Yes No

If Yes How Much?_____.

If You Smoked Previously When Did You Quit?_____.

Do You Drink Alcohol: (circle) Yes No

Daily_____ Weekly_____ Weekends_____ Occasionally_____

Review of Systems:

Please indicate if you are Experiencing any of the following symptoms.

_____Hearing Difficulty	_____Blurred Vision	_____Nosebleeds
_____Dysphagia (difficulty swallowing)	_____Coughing Blood	_____Chronic Cough
_____Shortness of Breath	_____Chest Pain	_____Nausea
_____Vomiting	_____Blood in Stool/Urine	_____Swelling
_____Joint Pain/Stiffness	_____Painful Urination	_____Syncope (fainting)

Have you ever been on Accutane? (Circle) Yes No

If yes, when ?_____

Have you ever experienced Herpetic outbreak or cold sores? Yes No

If yes, when ?_____

Women Only

Are you Pregnant: Yes No Are you Taking Birth Control Pills: Yes No

Are you Nursing: Yes No Do You Have Menstrual Problems: Yes No

Do you Wish to have a Pregnancy Test: Yes No

If Yes to any of the Above, Please Explain._____

_____

_____

Signature of Patient_____ **Date**_____

Physician Reviewed_____ **Date**_____

Time _____

Patients Name: _____ Date: _____

Thank you for visiting Elite Facial Plastic Surgery . We offer a wide variety of services to help you achieve your goal of facial/body rejuvenation. To help us better serve you, please take a few moments to complete this questionnaire to let us know your primary areas of concern and any procedures you may be interested in now or in the future. Thank you for your assistance.

SERVICES:

The following is a list of services we provide at Elite. Please indicate which cosmetic procedures may be of interest to you.

Surgical:

- ☐ Facelift
- ☐ Neck Lift
- ☐ Blepharoplasty (eyelid surgery)
- ☐ Browlift
- ☐ Cheek Implants
- ☐ Chin Implant
- ☐ Fat Transfer

- ☐ Laser Resurfacing: Face, Eyes, Mouth
- ☐ Otoplasty
- ☐ Rhinoplasty

Non-Surgical:

- ☐ Botox Treatments
- ☐ Injectable Fillers
  - ☐ Belotero
  - ☐ Restylane
  - ☐ Juvederm
  - ☐ Radiesse
  - ☐ Voluma
  - ☐ Bellafill
- ☐ Non-Surgical Rhinoplasty
- ☐ Coolsculpting
- ☐ Thermi Tight
- ☐ Kybella
- ☐ ThermiVa

I am thinking of having a procedure done in:

ASAP_____ 1-3 months_____ 3-6 months_____ 6-12 months_____

PATIENT HIPPA ACKNOWLEDGMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *HIPAA Privacy Notice*:

By subscribing my name below, I acknowledge that Elite Facial Plastic Surgery has provided a copy of the HIPAA Privacy Notice, and that I have read (or had the opportunity to read if I so chose) and understand my rights and ask questions regarding my rights and receive answers to my satisfaction, and agree to its terms.

_____ _____ _____

Name of Patient **Signature of Patient/Parent/Guardian** **Date**

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name:_____ Last four digits of his/her SSN or password (required):_____

Print Name: _____Last four digits of his/her SSN or password (required):_____

Print Name: _____Last four digits of his/her SSN or password (required):_____

I, _____, acting on behalf of my minor son/daughter_____,
Parent/Guardian (print) **Name of Patient**
as legal Personal Representative in all matters. If representative is a court appointed legal guardian, a copy of court documents must be provided and kept in medical records.

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home / Cell Telephone Number:
_____
_____OK to leave message with detailed information
_____Leave message with call back numbers only

Written Communication Address:
_____
_____OK to mail to address listed above
_____E-mail me at: _____

Work Telephone Number:
_____
_____OK to leave message with detailed information
_____Leave message with call back numbers only

Fax Communication:
_____
_____OK to Fax to the number listed above

Other: _____

_____ _____
Name of Patient (Print) Signature Date

Witness: _____ Date: _____