Patient Information

Today's Date_____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Languages Spoken: _____

Primary Phone: _____ Secondary Phone: _____ May we leave Voicemail ___Yes ___No Email ___Yes ___No

Sex: Female___ Male___ Marital Status: Single___ Married___ Widowed___ Separated___ Divorced___

How did you hear about us? _____ Pharmacy _____ Phone # _____

Patient Employer: _____ Spouse or Responsible Party: _____

Occupation: _____ Spouse or Resp. Party Employer: _____

Insurance

Name of Insurance Provider: _____ Primary Insured: _____ S.S. # _____

Insurance Phone #: _____ Member ID: _____ Group # _____

EmergencyContact: _____ Phone: _____ Relationship _____

Please mark all of Dr. Aya-ay's surgical and non-surgical procedures that interest you:

Surgical

___Facelift, Neck Lift or Brow Lift
___Breast Augmentation
___Liposuction
___Eyelid Surgery
___Breast Revision/Reconstruction
___Tummy Tuck
___Breast Lift
___Breast Reduction
___Body Lift, Arm Skin Reduction
___Scar Revisions
___Vaginal/Labia Rejuvenation
___Nipple Surgery

Non-Surgical

___Botox
___Dermal Fillers
___Anti-Aging, Prevention Skincare
___Sun Damage Repair
___Acne Treatments
___Scar treatments
___Eyelash Enhancements
___Spa Facial Services

Patient Medical History

Patient Name:_____ Date:_____

For Breast Consult, Bra Size:_____ Height_____ Weight_____

List Allergies:

□ Penicillin or Sulfa Reaction_____

□ Codeine, Morphine or other Narcotic Reaction_____

□ Betadine, Iodine Reaction_____

□ Latex Reaction_____

Other_____ Reaction_____

Medications: (Prescription & Over the counter)

□ Multi-Vitamins	□ Aspirin	□ Naprosyn
□ Tretinoin (retin-A)	□ Garlic	□ Diet Pills
□ Acutane	□ Vitamin E	□ Motrin
□ St. John's Wort	□ Ibuprofen (Advil, Motrin)	□ Ginseng
□ Ginko Baloba	□ Echinacea	

Other Medications taken that are not listed and dosage (Please include prescription, over the counter and any herbal or homeopathic medications):

_____ _____ _____

_____ _____ _____

Previous or current use of recreational drug? □ No □ Yes

List:_____

Previous history of tobacco use? □ No □ Yes If yes, when did you quit?_____

Current Tobacco use? □ No □ Yes How much?_____

Do you drink alcohol? □ No □ Yes How much?_____

How often? □ Occasionally □ Socially □ Daily □ Binge on Weekends

Please list previous surgical procedure and approximate dates:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you had any adverse or unusual reaction to anesthesia? If so, please list:_____

Review of Systems

General

- □ No Medical Problems
- □ Fevers
- □ Weight Loss
- □ Weight Gain
- □ Poor Nutrition
- □ Chronic Fatigue
- □ Skin Rashes

Skin

- □ Skin Cancer
- □ Melanoma
- □ Persistent Rash
- □ Yellow Jaundice

Eyes

- □ Cataracts
- □ Vision Loss
- □ Double Vision
- □ Glaucoma
- □ Wear Glasses/Contacts
- □ Dry Eyes
- □ Blurry Vision

Neurology

- □ Dizzy Spells
- □ Frequent Headaches
- □ Migraines
- □ Seizures
- □ Stroke
- □ TIA
- □ Tremors
- □ Fibromyalgia
- □ Numbness or Tingling

Liver History

- □ Hepatitis: A / B / C
- □ Cirrhosis
- □ Gall Stones
- □ Jaundice

Gastrointestinal

- □ Ulcers
- □ Abdominal Pain
- □ Nausea
- □ Heartburn
- □ Blood in Stool
- □ Constipation
- □ Diarrhea
- □ Diverticulitis
- □ Acid Reflux
- □ Hemorrhoids
- □ Irritable Bowel
- □ Loss of Appetite

Cardiovascular

- □ Chest Pain
- □ Heart Attack
- □ Irregular Heart Beat
- □ High Blood Pressure
- □ Feel Heart Racing
- □ High Cholesterol
- □ Pacemaker
- □ Heart Murmur
- □ Scarlet Fever
- □ Need Prophylactic Antibiotics
- □ Ankle / Leg Swelling
- □ Chronic Fatigue

Musculoskeletal

- □ Back Pain
- □ Neck Pain
- □ Arthritis
- □ Use Wheelchair
- □ Joint Pain
- □ Limited Motion in Joints
- □ Muscle Weakness
- □ Swelling In Joints

Ear, Nose, Throat

- □ Hearing Loss
- □ Sore Throat
- □ Sinus Infection

- ☐ Difficulty breathing
- ☐ Snoring / Apnea
- ☐ Swallowing Difficulties

Respiratory

- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Lung Cancer
- ☐ Emphysema
- ☐ COPD
- ☐ Require Oxygen
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Cough
- ☐ Wheezing
- ☐ Pulmonary Embolism

Blood/Lymphatic

- ☐ Anemia
- ☐ Swollen Glands
- ☐ Bleed/Bruise Easily
- ☐ Blood Transfusion
- ☐ Hemophilia
- ☐ Clotting Problems
- ☐ Blood Clots in Legs
- ☐ Blood Thinner

Psychiatric

- ☐ Depression
- ☐ Anxiety

Gynecologic

- ☐ Hysterectomy
- ☐ Abnormal PAP
- ☐ Cervical Cancer
- ☐ HIV
- ☐ Hepatitis C
- ☐ Cold Sores
- ☐ Genital Herpes
- ☐ Genital Warts
- ☐ HPV

Tanning

- ☐ Always Burns, Never Tans
- ☐ Always Burns, Tans w/ Difficulty
- ☐ Burns Mildly, Tans Slowly
- ☐ Rarely Burns, Tans w/ Ease
- ☐ Very Rarely Burns, Tans Very Easily
- ☐ Never Burns, Tans Very Easily

Female/Breast History

- ☐ Breast Mass- L-Breast / R-Breast
- ☐ Nipple Discharge-L-Breast / R-Breast
- ☐ Lumps or recent changes
- ☐ I have Irregular Periods
- ☐ I am Menopausal
- ☐ Pregnancies: _____ (#)
- ☐ Births: _____ (#)
- ☐ Breast Feeding: Past / Present

Kidney History

- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Kidney Infection
- ☐ UTI / Bladder Infection

Extremity History

- ☐ Spider Veins
- ☐ Varicose Veins
- ☐ Leg Swelling
- ☐ Difficulty Walking

Endocrine History

- ☐ Diabetes Controlled By:

  Diet / Insulin / Oral Meds
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Excessive Thirst / Hunger
- ☐ Frequent Urination
- ☐ Excessive Sweating

Cancer History

- ☐ Skin: Melanoma / BCC / SCC
- ☐ Breast
- ☐ Lung
- ☐ Live
- ☐ Colon

Anesthesia History

- ☐ Difficult Intubation
- ☐ Difficult Extubation
- ☐ Malignant Hyperthermia
- ☐ Excessive Nausea /Vomiting

Please list any other medical conditions:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Family History:

Family Member Inflicted:

- □ Diabetes _____
- □ Cancer _____
- □ Malignant Hyperthermia _____
- □ Liver Disease _____
- □ Lung Disease _____
- □ Endocrine Disease _____
- □ High Blood Pressure _____
- □ Heart Disease _____
- □ Malignant Hyperthermia _____
- □ Autoimmune Disease _____
- □ Kidney Disease _____
- □ High Cholesterol _____
- □ Anesthesia Problems _____
- □ Stroke _____
- □ Bleeding Disorders _____
- □ Problems with anesthesia _____
- □ Cancer-Type _____ _____
- □ Other: _____ _____

PLEASE READ ALL OF FOLLOWING CAREFULLY

Patient Name: _____

Privacy and Confidentiality Notice

We understand that many patients are concerned about the privacy surrounding their decision to have plastic surgery. Dr. Aya-ay and her staff believe that your personal and medical information should remain confidential. We pledge to safeguard the information you provide to the best of our abilities. We are required to provide you with a copy of our privacy practices, which states how we may use and/or disclose your health information. By signing below, you acknowledge review of Notice of Privacy Practices and authorize the release of medical information for the typical uses and disclosures of health information. (Please review laminated copy of Notice of Privacy Practices attached and return to front desk)

Signature: _____ Date: _____

Please list any family members, friends, etc...that you authorize the release of information to:

_____

_____

_____

Consent to Photographs

Please be advised that Dr. Aya-ay is a board certified plastic surgeon and is required to take photographs as part of your medical record. I understand the photographs may also be provided to my insurance company if requested. I understand that photographs may be used for patient education purposes. It is understood that I shall not be identified by name and my face will not be shown when possible. (Please note, in breast cases, the face is not shown.) It is also understood that treatment of any kind will NOT be rendered without photographs, as it is part of the exam and a critical part of my patient chart. By signing below, I hereby authorize Dr. Aya-ay and/or a staff member to take photographs of me or parts of my body before, during and after treatments as requested by Dr. Aya-ay.

Signature: _____ Date: _____

FMLA/Disability Information/Consent

Family Medical Leave Act is a law that protects you from losing your job due to a medical disability and allows you up to 12 weeks of unpaid leave for a serious medical condition. If this is available to you and your employer requires our office to fill out any paperwork, we ask that you allow at least 7 business days to complete. I understand that the office charges a $35 fee to complete any paperwork required by your employer, I authorize the release of any medical information/records in regards to my disability/FMLA paperwork.

Signature: _____ Date: _____

Consent for Smoking

SMOKER:

I, _____, DO smoke cigarettes and/or use other tobacco products and I understand the risks and complications of a surgical procedure as a smoker. I have been made aware that the risks and complications are significantly increased if I do not stop smoking at least 4 weeks prior to surgery.

NON-SMOKER:

I, _____, DO NOT smoke or use any other nicotine product.

Signature: _____ Date: _____

Insurance Patients

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Melanie L. Aya-ay, M.D. Plastic Surgery, P.L. for all covered medical services and supplies provided to me during all courses of treatment and care provided by Melanie L. Aya-ay, M.D. Plastic Surgery, P.L. and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with Melanie L. Aya-ay, M.D. Plastic Surgery, P.L. of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Melanie L. Aya-ay, M.D. Plastic Surgery, P.L.

In Network/Out of Network

I understand that some insurance carriers may have physicians who are contracted with that insurance carrier to accept their fees. These physicians are termed, "participating providers". It is also my understanding that my insurance plan allows me the right to choose the doctor I prefer to provide my medical/surgical care even if she is not a participating provider. If Melanie Aya-ay, M.D. is not a provider, it is likely that there will be a difference between the amount the insurance carrier deems usual and customary, and the actual fee's for service rendered. I understand that the financial policy of Melanie Aya-ay, M.D.'s office is that I will pay any deductible and copayment prior to surgery. Melanie Aya-ay, M.D.'s office will file my insurance claim for her services with my insurance carrier.

Financial/Insurance Agreement

I understand that it is my responsibility as a patient to know my insurance plan benefits and coverage, including any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation. I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered. I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance. I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

Once my insurance company has made payment, I will be responsible for any balance remaining on my account. I agree to make those payments in a timely fashion. I understand that Dr. Aya-ay submits to my insurance as a courtesy and if payment is not made by insurance in a timely manner, then I agree to pay Dr. Aya-ay directly.

Please be advised that health insurance does not cover services they deem to be cosmetic. Please be advised that Dr. Aya-ay will not submit any procedures to insurance that she feels are cosmetic. I agree to be personally and fully responsible for payment, and understand that this practice will not submit a claim for any services we deem to be cosmetic.

I understand and agree that I am financially responsible for all charges for any and all services rendered.

Signature: _____ Date: _____

Print Name: _____

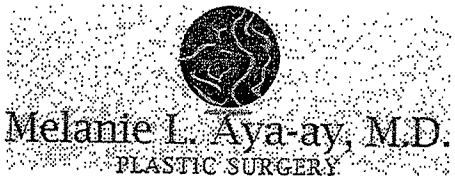
Cosmetic Patients

For all cosmetic consultations, $75 consultation fee will be due. All other charges will be discussed at time of consultation and all fees are to be paid in full prior to any surgical procedure. I understand that I am financially responsible for any and all charges for services rendered.

Signature: _____ Date: _____

Print Name: _____

**We kindly ask that you read through and sign both portions of this page even if one or the other does not apply to you. We want to make sure that all patients are aware of ALL of our policies. Thank you.



INTERNET/WEB/SOCIAL MEDIA PHOTO RELEASE CONSENT FORM

(Please note this consent is optional)

I, _____, give my permission to Dr. Melanie Aya-ay to use pre-operative, intra-operative, and postoperative photographs, without compensation, for website, social media, internet marketing and educational/teaching purposes. No patient identifiers such as name or medical record number will be associated with the photos. When possible, any identifying features of the photos will be concealed. This may not be possible with facial surgical procedures.

I further agree to hold Dr. Melanie Aya-ay free and harmless from all claims arising from the use of said photographs when used within the scope described above.

_____ _____

Signature **Date**

_____ _____

Signature of parent/guardian **Date**

(If above is a minor)

_____ _____

Witness Signature **Date**