Melanie L. Aya-ay, M.D.
PLASTIC SURGERY

Patient Information

Today's Date:_____

Patient Name: _____ **Date of Birth:**_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Email Address:_____ **May we Leave Email:** Yes No

Primary Phone:_____ **Secondary Phone:**_____ **May we Voicemail:** Yes No

Sex: Female Male **Marital Status:** Single Married Widowed Separated Divorced Decline

Primary Care Physician: _____ **Phone #:**_____

Pharmacy:_____ **Phone #:**_____

How did you hear about us?_____

_____

Emergency Contact Information:

Name:_____ **Phone #:**_____ **Relationship:**_____

***Insurance Information*:**

Insurance Provider:_____

Primary Insured & Relationship:_____ **D.O.B:** _____

Phone Number:_____ **Member ID:**_____ **Group Number:**_____

If Tricare is your insurance provider, please include social security number of subscriber:_____

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Please circle any surgical or non-surgical procedures that interest you:

Surgical:

Facelift/Neck Lift/Brow Lift

Liposuction

Breast Revision/Reconstruction

Breast Lift

Body Lift, Arm Skin Reduction

Vaginal/Labia Rejuvenation

Breast /Augmentation

Eyelid Surgery

Tummy- tuck

Breast Reduction

Scar Revision

Nipple Surgery

Non-surgical:

Botox/Jeaveau

Anti-aging, Prevention Skincare

Acne Treatments

Eyelash Enhancements

Laser

Broad Band Light (BBL)

Dermaplaning

Dermal Fillers

Sun Damage Repair

Scar Treatments

Spa Facial Services

Peels

Instalift

Patient Medical History

Patient Name:_____Date:_____

For Breast Consult, Bra Size:_____Height:_____Weight:_____

Please List Allergies:

- ☐ Penicillin or Sulfa
- ☐ Codeine, Morphine, or other Narcotic
- ☐ Betadine, Iodine
- ☐ IV Contrast
- ☐ Latex
- ☐ Other:_____

Medications: (Prescription & Over the Counter)

Multi-Vitamins	Aspirin	Naprosyn
Tretinoin (retin-A)	Garlic	Diet Pills
Accutane	Vitamin E	St. John's Wort
Ginseng	Ginkgo Biloba	Echinacea

Ibuprofen, Motrin, Advil

Other Medications (Please include Prescription & dosage, Over the Counter, and any Herbal or Homeopathic medications):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous or current use of Recreational Drugs? Yes No

If yes, please write type:_____

Previous or current history of tobacco use? Yes No

If yes, when did you quit?_____

Do you drink alcohol? Yes No

If yes, how much:_____

How often? Occasionally Socially Daily Binge on the Weekends

Patient Medical History

Please list any Medical Conditions (current or past):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list previous surgical procedures and approximate dates:

_____ Date:_____	_____ Date:_____
_____ Date:_____	_____ Date:_____
_____ Date:_____	_____ Date:_____
_____ Date:_____	_____ Date:_____
_____ Date:_____	_____ Date:_____
_____ Date:_____	_____ Date:_____

Have you had any 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
- ☐ Wears Glasses/Contacts
- ☐ Dry Eyes
- ☐ Blurry Vision

Liver History

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

Neurology

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

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
- ☐ Feels 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

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

Review of Systems

Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar

Gynecologic

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

Female Breast History

- ☐ Breast Mass: Left Breast/ Right Breast
- ☐ Nipple Discharge: Left Nipple/ Right Nipple
- ☐ Lumps or Recent Changes
- ☐ Irregular Periods
- ☐ 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

Anesthesia History

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

Cancer History

- ☐ Skin: Melanoma / BCC / SCC
- ☐ Breast: Left / Right / Both
- ☐ Lung
- ☐ Liver
- ☐ Colon

Tanning History

- ☐ Always burns, never tans
- ☐ Always burns, tans with difficulty
- ☐ Burns Mildly, tans slowly
- ☐ Rarely burns, tans with ease
- ☐ Very rarely burns, tans very easily
- ☐ Never burns, tans very easily

Family Health History

Medical Condition & Family Member Inflicted:

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

_____

_____

PLEASE READ ALL OF THE FOLLOWING CAREFULLY

Patient Name:_____

Privacy and Confidentiality Notice

We understand that many patients are concerned about the privacy surrounding their decisions 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 provided to the best of our abilities. We are required to provide you with a copy of our privacy practice, which states how we may use and/or disclose your health information. By signing below, you acknowledge review of Notice 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 pf me as part of my body before, during, and after the 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 14 business days to complete. By signing below, you understand that the office charges a $35 fee for each surgery or each stage of surgery to complete any paperwork required by your employer. By signing, you also authorize the release of any medical information/records in regards to your disability/FMLA paperwork.

Signature:_____ **Date:**_____

Consent for Smoking

Smoker:

I, _____, DO smoke cigarettes and/or use other tobacco products and I understand the risk and complications of a surgical procedure as a smoker. I have been made aware the risk 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:**_____

Refund/Returned Check and Credit Card Fees

For any surgery balances paid with a credit card, a 3% credit card processing fee will be added to the balance. For credit card payment refunds, a 3% processing fee will be deducted from any refund. Any check that is returned for insufficient funds will be charged a $30 fee.

Signature:_____ **Date:**_____

Print Name:_____

No Show Fee:

In order to avoid no shows, when booking appointments we will take a credit card number to have on file. The $100 fee will not be applied unless; you fail show up to an appointment without prior notification. Please note the cancellation has to be done 24 hours in advance on a business day, no emails or voice message will be accepted.

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. and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained 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 insurances carriers may have physicians who are contracted with that insurance carrier to accept their fees. Theses physicians are termed "participating providers". It is also my understanding that my insurance plan allows me to the right 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 fees 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 deducible, copayment, co-insurance, out-of-network, usual and customary limits, 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, conformation 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.

Insurance Patients

Financial/Insurance Agreement (continued): Please be advised that Dr.Aya-ay will not submit any procedures to insurance that are cosmetic or not medically necessary. This includes revisions of cosmetic surgeries. I agree to be personally and fully responsible for payment, and understand that this practice will not submit a claim for any services deemed to be cosmetic. I understand and agree that I am financially responsible for all charges for any and all services rendered.

For all insurance visits a copay/co-insurance may be due. Please review and understand your insurance benefits/responsibilities. Depending on your insurance benefits you may have a deductible or other fees due prior to your surgery. I understand that any lab work, imaging or pathology ordered for surgery will be billed to your insurance separately if applicable. I understand that I am financially responsible for any and all charges for services rendered.

Signature:_____ **Date:**_____

Print Name:_____

Insurance Surgery Cancellation/Rescheduling Policy: Preparing for a surgery requires careful planning and coordination. Preparation for your surgery is performed by Dr. Aya-ay, our Scheduling/ Billing Specialist, our Nurse Practitioner and Medical Assistants. It includes communicating/scheduling with hospital or surgical facility, booking surgery, dictating history & physicals, ordering of implants or other supplies, insurance authorization, preparing pre-op paperwork and prescriptions, etc... It is important that when you schedule your surgery, you have thoroughly checked your personal calendar to make sure that your scheduled date is ideal for you.

We kindly ask for at least 4 weeks prior notice if you need to cancel or reschedule your surgery. If surgery is not canceled 4 weeks prior to surgery date, we will require a non-refundable $250 cancellation fee. We thank you in advance for your cooperation and understanding of the surgical scheduling process. By signing below, you understand and agree to this policy.

Signature:_____ **Date:**_____

Print Name:_____

Cosmetic Patients

For all cosmetic consultation, a $100 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 any lab work, prescriptions, imaging or pathology ordered for surgery are not included in the surgical quote and will be billed separately if applicable. 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 and the previous one even if one or the other does not apply to you. We want to make sure that all our patients are aware of ALL of our policies. Thank you. **

Melanie L. Aya-ay, M.D.
PLASTIC SURGERY

Internet / Web / Social Media Photo Release Consent Form

(Please note this consent is optional)

I,_____, give my permission to Melanie Aya-ay, M.D. Plastic Surgery, P.L. to take and use pre-operative, intra-operative, and postoperative photographs and videos, 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 procedures.

I further agree to hold Melanie Aya-ay, M.D. Plastic surgery, P.L. and all associated staff 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 if Patient is a Minor:_____**Date:**_____

Witness signature:_____**Date:**_____