Ocean
Plastic Surgery Center

PATIENT PROFILE

Please print and fill out profile completely.

First Name:_____ Mid. Initial: _____ Last Name:_____

DOB:_____/_____/_____ Age:_____ Occupation: _____

Address: _____ City:_____

State:_____ Zip:_____

Phone:_____ Email:_____

Do we have permission to use your contact info listed above regarding your appointments, procedures, quotes?
Circle either YES or NO for each:

USPS MAIL: *YES / NO* ***PHONE/ VOICEMAIL:*** *YES / NO* ***EMAIL:*** *YES / NO* ***TEXT:*** *YES / NO*

Emergency Contact: _____

What is their relation to you?_____Phone:_____

How were you referred to us? Previous Patient Name: _____

Online Research: RealSelf Yelp OceanPlasticSurgery.com Facebook Instagram YouTube

What did you Google that lead you to our website? _____

What procedures are you interested in speaking to Dr. Aiello about today? _____

Do you have a time frame for surgery? _____

Do you need information on financing your surgery? _____

OPSC Office Use:

_____

_____

_____

_____

CONSENT TO USE ELECTRONIC COMMUNICATION

Electronic Communication methods include email, text message, video conferencing, social media or third party website communication. Be informed that these methods are not confidential means of communication. If you use these methods to communicate with Ocean Plastic Surgery Center, there is a reasonable chance that a third party may be able to intercept those messages. These kinds of parties include, but are not limited to:

- People in your life with access to your phone or other devices that you use to read and write messages.
- Your employer, if you use your work email to communicate with Ocean Plastic Surgery Center.
- Third parties such as server administrators and others who monitor and/or intercept Internet traffic.

CONSENT TO THE USE OF ELECTRONIC MESSAGES INCLUDES YOUR AGRTEEMENT WITH THE FOLLOWING CONDITIONS:

- All electronic messages to or from you may be printed out or stored electronically by Ocean Plastic Surgery Center and made part of your medical record.
- Ocean Plastic Surgery Center may forward messages internally to staff as necessary for diagnosis, treatment, payment, health care operations, and other purposes.
- Although Ocean Plastic Surgery Center will endeavor to read and respond promptly to a message from you, we cannot guarantee that any particular message will be read and responded to within any particular period of time. Thus, you agree that you will not use email or other electronic messages for medical emergencies or other time-sensitive matters.
- It is your responsibility to follow up and/or schedule an appointment, if warranted. If your message requires or invites a response from Ocean Plastic Surgery Center and you have not received a response within a reasonable time period, it is your responsibility to follow up to determine whether the intended recipient received the message and when the recipient will respond.
- You should not use electronic messages for communications regarding sensitive medical information. Electronic communications will be restricted to appointment logistics and medical information of brief nature. I understand that communication will not be an appropriate venue for sensitive subject matter.
- You are responsible for protecting your password or other means of access to electronic messages. Ocean Plastic Surgery Center is not liable for breaches of confidentiality caused by you or any third-party. If there are people in your life whom you don't want to access these communications please consider ways to keep your communications safe and confidential such as password protecting your personal electronic devices.
- Ocean Plastic Surgery Center will not knowingly engage in electronic messages that are unlawful.

By signing this form, I _____, acknowledge that:

1. I have read and fully understand the risks, the limitations, the conditions of use and instructions for use of electronic communication. I understand and accept the risks associated with the use of electronic communications with Ocean Plastic Surgery Center. I also understand that I am not required to sign this agreement in order to receive treatment.
2. I understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with Ocean Plastic Surgery Center using electronic communication may not be encrypted. Despite this, I agree to communicate with the Physician or the Physician's staff using these methods with a full understanding of the risk.
3. I acknowledge and authorize Ocean Plastic Surgery Center to deliver or cause to be delivered text messages from the following telephone number: 562-594-5996. I acknowledge and understand that such messages may be delivered to me by an automated texting system.
4. I also understand that I or the Physician may, at any time, withdraw this option of electronic communications by providing the other party with written notice of such withdrawal.

Signature:_____ Date:_____

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USE & DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPTIONS

I understand that as part of my health care, OCEAN PLASTIC SURGERY CENTER originates and maintains paper and/ or electronic records describing my heath history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means of which third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that OCEAN PLASTIC SURGERY CENTER is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that OCEAN PLASTIC SURGERY CENTER reserved the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should OCEAN PLASTIC SURGERY CENTER change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

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.

Please **circle one** and **sign**: I fully understand and **accept / decline** the terms of this consent:

Signature: _____ **Date:** _____

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PERSONAL HEALTH HISTORY (PAGE 1)

Please print and fill out profile completely. If there is not enough room to write, turn and write on back of page.

Consultation Date: _____Name:_____

MEDICAL HISTORY: PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

☐ HIGH BLOOD PRESSURE	☐ DIABETES	☐ BACK OR NECK INJURIES	☐ EMPHYSEMA
☐ HEART ATTACK/HEART DISEASE	☐ THYROID PROBLEMS	☐ CHRONIC BRONCHITIS	☐ CATARACTS
☐ IRREGULAR HEART BEAT/MURMUR	☐ HEPATITIS	☐ BOWEL OBSTRUCTIONS	☐ PNEUMONIA
☐ CHEST/HEART PAIN	☐ KIDNEY DISEASE	☐ STOMACH ULCERS	☐ ASTHMA
☐ COLD SORES/HERPES/SHINGLES	☐ ABNORMAL X-RAY	☐ EXCESSIVE BLEEDING	☐ RECENT COLD/FLU
☐ THROMBOPHLETBITIS /CLOTTING	☐ SEIZURES	☐ CHRONIC SINUSITIS	☐ AIDS/HIV
☐ ABNORMAL MAMMOGRAM	☐ ANEMIA	☐ VISUAL IMPAIRMENT	☐ BLADDER INFECTION
☐ BLOOD TRANSFUSIONS	☐ STROKE	☐ TUBERCULOSIS	☐ WEIGHT LOSS/GAIN
☐ CANCER OF: _____		☐ HERNIA OF: _____	

☐ ADVERSE REACTION AFTER ANESTHESIA (Including muscle disorder, high fever, chocolate colored urine.)

IF YOU CHECKED ANY OF THE ABOVE HEALTH ISSUES: List details such as when you were diagnosed, when you last experienced any issues relating to it and if you have been treated by a physician for it: _____

_____

_____

DO YOU HAVE ANY OTHER HEALTH RELATED ISSUES? _____

☐ **LIST ALL HOSPITALIZATIONS.** WHEN/WHY:

_____

_____

_____

_____

☐ **LIST ALL PREVIOUS SURGERIES.** PROCEDURES/DATES:

☐ **ARE YOU ALLERGIC TO ANY MEDICATION?** LIST SIDE EFFECTS: _____

LIST ALL MEDICATIONS AND SUPPLEMENTS YOU TAKE WITH ANY REGULARITY:

(INCLUDE HERBS, VITAMINS, WORK OUT BOOSTERS, DIET TEAS, OVER THE COUNTER PAIN RELIEVERS AND SLEEP MEDIATIONS, ETC.)

_____

_____

_____

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PERSONAL HEALTH HISTORY (PAGE 2)

Please print and fill out profile completely. If there is not enough room to write, turn and write on back of page.

Consultation Date: _____Name: _____

PERSONAL HISTORY: HEIGHT: _____ WEIGHT: _____

- Number of Births: _____(Natural/ Cesarean?) Your Children's Ages:_____
- Do You Exercise? ☐ YES-Type/Frequency: _____ ☐NO Exercise
- Do You Follow a Restricted Diet? ☐ YES-Type: _____ ☐NO Restricted Diet
- Do You Use ANY NICOTINE Products? ***(Includes cigarettes, cigars, vaping, hookah, patches and gums.)***

  ☐ Never ☐ NO-Quit Date: _____ Number of Years You Smoked: _____

  ☐ YES-Type/Frequency: _____

- Do You Drink Alcohol? ☐ NO ☐ YES-How many drinks per day? _____
- Do You Use Illegal Drugs? ☐ NO ☐ YES-Type/Frequency: _____

Primary Care Physician: _____Phone:_____

Have You Had Any of the Following Tests? If **YES**, When?
Bloodwork: _____ Chest X-Ray: _____ EKG: _____ MRI/CT-Scan: _____ Mammogram: _____

Were Any Results Abnormal? _____

FAMILY HISTORY: If Checked, List Relation:
☐DIABETES: _____ ☐BLEEDING/CLOTTING ISSUES: _____
☐STROKE: _____ ☐ HEART DISEASE: _____
☐CANCER: _____ ☐HYPERTENSION: _____
☐**Adverse Reaction After Anesthesia** (Muscle disorder, high fever, chocolate colored urine.) _____

I CERTIFY THAT I HAVE DISCLOSED MY COMPLETE HISTORY TO THE BEST OF MY KNOWLEDGE:

PATIENT SIGNATURE: _____ DATE: _____

OPSC CONSULTANT SIGNATURE: _____