LUCIAN J. RIVELA, M.D., F.A.C.S.
COSMETIC PATIENT INFORMATION

NAME:_____

DOB:_____AGE:_____ SS# (OPTIONAL):_____

ADDRESS:_____

CITY:_____ STATE:_____ZIP:_____

HOME PHONE:_____ WORK PHONE:_____

CELLULAR:_____PLEASE CIRCLE PREFERRED CONTACT NUMBER

PHARMACY PHONE NUMBER: _____

MARITAL STATUS: M D S W SEP

REASON FOR VISIT:_____

OTHER AREAS OF CONCERN/OR PROCEDURES YOU ARE INTERESTED IN SUCH AS:

☐ Fine Lines and Wrinkles ☐ Major Lines around nose and mouth ☐ Age Spots/Sun Spots

☐ Spider Veins ☐ Unwanted Hair ☐ Bags under eyes or eyelids ☐ Breasts

☐ Excess fullness/loose skin in ABS ☐ Excess fullness in the hips, thighs or buttocks regions

☐ Lip Size or Shape ☐ Other _____

REFFERRED BY: Newspaper Magazine Ad Phone Book Previous Patient
Internet Physician Other

PLEASE LIST REFERRAL NAME/LOCATION:_____

EMERGENCY CONTACT

NAME:_____ RELATIONSHIP:_____

HOME PHONE:_____ WORK PHONE:_____

PATIENT'S EMPLOYER INFORMATION

EMPLOYER:_____ PHONE#_____

ADDRESS:_____

CITY:_____ STATE:_____ZIP:_____

I understand the procedure (s) I seek will be cosmetic in nature. I further understand that Dr. Rivela will not accept insurance for this (these) procedure (s) since they are cosmetic procedures. I understand I will be fully responsible for all of the surgical fees for the surgery/treatment that I seek and understand this consent is irrevocable and final.

SIGNATURE:_____ DATE:_____

HEALTH HISTORY

Patient Name: _____ Date: _____

Age: _____ Date of Birth: _____ HT: _____ WT: _____ Marital Status: _____

What is the reason for your visit: _____

MEDICAL HISTORY: Do you, or have you had any of the following?

	Yes	No		Yes	No
Rheumatic Fever/Scarlet Fever	□	□	Cancer	□	□
Heart Trouble	□	□	Kidney	□	□
High Blood Pressure	□	□	Eye Disease	□	□
Irregular Heartbeat	□	□	Liver Disease	□	□
Heart Murmur	□	□	Thyroid Problems	□	□
Chest Pains	□	□	Chronic Lung Disease	□	□
Shortness of Breath	□	□	Blood Disorders	□	□
Hepatitis	□	□	HIV	□	□
Diabetes	□	□	Skin Diseases	□	□
Fever Blisters	□	□	Herpes	□	□
Skin Sensitivity to Adhesive Tape	□	□	Large Scars or Keloids	□	□
Have you ever had psychiatric problems/been under the care of a psychiatrist?				□	□

If you answered yes to any question, please explain: _____

_____

HOSPITALIZATIONS AND/OR PREVIOUS SURGERY: Please list with dates:

_____

_____

ALLERGIES: Are you allergic to any medications? Yes No If yes, please list medication and type of reaction (s) _____

MEDICATIONS: Please list **all medications** you are currently taking, including herbal medicines, diet pills, accutane and over-the-counter medications. _____

_____

_____

FAMILY HISTORY:

Check (x) if blood relatives have had any of the following:

Relationship to you

□ Breast Cancer _____

□ Skin Cancer _____ Type of skin cancer if know _____

□ Other skin diseases _____ Type if known _____

□ Keliod Scars _____ □ Diabetes _____

□ Bleeding Disorders _____ □ Heart Disease/stroke _____

□ Prolonged Bleeding _____ □ Other _____

HEALTH HABITS: Do you smoke? No □ Yes □ _____ per day

WORK STATUS: Are you currently working? Yes Occupation: _____
No Retired

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for errors or omissions that I may have made in completion of this form.

_____ _____
Signature Date

_____ _____
Reviewed by Date

File name: Patient Health History2016

Lucian J. Rivela, M.D..., P.A.

Patient Consent and Acknowledgement of Receipt of Privacy Notice

Our Notice of Privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed of used for treatment, payment, or healthcare operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease. the restrictions requested.

I hereby authorize Dr. Rivela and his staff to release information pertaining to my condition and/or care to only those family members or authorized representative as listed below:

_____

Name of Family Member or Authorized Representative Relationship

I authorize Dr. Rivela and his staff to contact me and/or my family member/personal representative in the following ways.

*******Please check all that apply*******

☐ **Phone** ☐ **Fax** ☐ **E-Mail** **(Office Promotions)** **U.S. Mail** ☐ **YES** ☐ **NO** **(Office Promotions, Etc.)**

E-Mail Address :_____(Please Print Clearly)

_____

Patient's Signature Date

If not signed by patient, please indicate relationship:
( ) parent or guardian of minor patient under 12 years old
( ) guardian or conservator of incompetent patient

File Name: HIPAA2016