



HEDGEWOOD PLASTIC SURGERY
FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY
THOMAS H. M. MOULTHROP, M.D., F.A.C.S
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2427 SAINT CHARLES AVENUE • NEW ORLEANS, LOUISIANA 70130 • (504) 895-7642

Date: _____

Patient Name: _____
First Middle Last

Date of Birth: _____ Age: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer Name: _____

Occupation: _____ Work Phone: _____

REASON FOR VISIT

What area(s) of the face or neck are you interested in having improved?

- Neck/Jowls/Jawline Eyes/Brow Nose Chin Ears
 Lips/Injectables Skin/Wrinkles Other: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

- I am a former patient of Calvin M. Johnson, Jr., M.D. Patient Referral: _____
 Event Friend: _____
 Internet search Dr. Referral: _____
 Other: _____

EMERGENCY CONTACT

Name: _____

- Spouse Parent/Guardian Other: _____

Home phone: _____ Cell Phone: _____ Work phone: _____

HEDGEWOOD PLASTIC SURGERY

Medical Evaluation

Patient Name: _____ Date: _____

Height: _____ Weight: _____

Primary care physician: _____

How is your general health? _____

When was your last physical examination? _____

MEDICAL ISSUES

- | | | |
|--|---|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Unusual scarring/Keloids |
| <input type="checkbox"/> Asthma/Lung Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease- |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Liver/Kidney Disease | <input type="checkbox"/> Arrhythmias |
| <input type="checkbox"/> Blood Clots/DVT/PE | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Fever Blisters/Herpes | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Stents |

PAST SURGICAL HISTORY

Have you undergone general anesthesia ("been put to sleep")? YES NO

Have you or a family member had an unusual reaction, such as nausea or vomiting, to anesthesia? YES NO

Describe: _____

Please list all surgeries (major or minor):

ALLERGIES/SENSITIVITIES

Are you allergic to latex or tape? YES NO

Are you allergic to any medications? YES NO

Drug/Reaction: _____

MEDICATIONS

Please list both prescribed and over-the-counter, including inhalers, eye drops, vitamins, and supplements:

Do you take aspirin? YES NO Frequency taken: _____

Do you take ibuprofen (Advil/Motrin/Nuprin)? YES NO Frequency taken: _____

EYES

Dry eyes or use drops regularly? YES NO
Recent visual exam? YES NO
Eye or eyelid surgery? YES NO If yes, what type? _____

NOSE

Difficulty breathing through nose? YES NO
Prior trauma to nose? YES NO
Sinus or nasal surgery? YES NO If yes, when/where? _____

FACE

Previous face or neck surgery? YES NO
Radiation therapy to head or neck? YES NO
Facial paralysis or weakness? YES NO
Laser resurfacing or chemical peel? YES NO
Rosacea or highly sensitive skin? YES NO

SKIN CARE

Are you receiving any Injectables, such as Botox or fillers? YES NO

By whom? _____

Do you have a physician recommended skin care program? YES NO

Describe: _____

Who/where is your regular stylist or salon? _____

SOCIAL HISTORY

Have you used any nicotine products (gum, vaporizer, patch) or tobacco in the past year? YES NO

Do you have more than two alcoholic beverages per day? YES NO

Have you been treated for any drug or alcohol dependency? YES NO

Have you ever received psychiatric treatment? YES NO

Is there any reason you may be at risk for HIV/AIDS? YES NO

Have you had any recent crises in your life? YES NO

Signature

Date

HEDGEWOOD PLASTIC SURGERY Consent to Communicate

Patient Name: _____ Date: _____

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)
<input type="checkbox"/> Call Home Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
<input type="checkbox"/> Call Cell Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
<input type="checkbox"/> Call Work Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
<input type="checkbox"/> Send Text			<input type="checkbox"/>
<input type="checkbox"/> Send Email			<input type="checkbox"/>

If it's ok to leave a message with another person, please list below:

Name	DOB	Relationship	Ok to Release Results	Any Comments:
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Signature

Date

HEDGEWOOD PLASTIC SURGERY

HIPAA Information and Consent Form

Patient Name: _____ Date: _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____