Waldman Schantz Plastic Surgery
3288 Eagle View Lane Ste 300
Lexington, KY 40509
(859) 254-5665
www.WaldmanPlasticSurgery.com

Patient Information Form

Patient Name: _____ Today's Date: _____

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

Home Phone: _____ Cell Phone: _____ Cell Carrier: _____

DOB & Age: _____

Social Security Number: _____ Email Address: _____

Who is your primary care physician? _____

How did you hear about us?
☐ WaldmanPlasticSurgery.com ☐ Patient Referral: _____ ☐ Dr. Referral: _____
☐ Facebook ☐ Google/Internet Search

Check any procedures that interest you:

Facial Procedures		Body Contouring	Medical Skin Care
☐ Face/Neck Lift	☐ Botox, Dysport, Xeomin	☐ Liposuction	☐ Glycolic Peel
☐ Brow Lift	☐ Facial Fillers	☐ Tummy Tuck	☐ Sciton Skin Tyte
☐ Eyelid Lift	☐ Fractional Laser Peel	☐ Breast Augmentation	☐ Medical Facials (Peels)
☐ Nasal Surgery	☐ Hair Replacement	☐ Breast Lift	☐ Photo Rejuvenation (IPL)
☐ Ear Pinning	☐ Skin Care	☐ Breast Reduction	☐ Microdermabrasion
☐ Cheek or Chin Implants	☐ CO2 Laser	☐ Arm Lift	☐ Facial Vein Removal
☐ Lip Enhancement	☐ Skin Care	☐ Body Lift	☐ Hydrating Facial
☐ Ear Lobe Repair	☐ Lesion Removal	☐ Coolsculpting	☐ Microneedling

Would you like a complimentary skincare consultation? ☐ Yes ☐ No
How do you plan on paying for today's visit? ☐ Visa ☐ American Express ☐ Cash ☐ Other:_____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

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

Waldman Schantz Plastic Surgery
3288 Eagle View Lane Ste 300
Lexington, KY 40509
(859) 254-5665

www.WaldmanPlasticSurgery.com

Consent to Communicate

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)	Best Time to Call*
☐ Send Text Page	-	-	☐	-
☐ Text Appt Reminders – if so, list cell carrier:				
☐ Text Marketing Info – if so, list cell carrier:				
☐ Send Email	-	-	☐	-
☐ Email Appt Reminders				
☐ Email Medical Info				
☐ Email Marketing Info				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	

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

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

Waldman Schantz Plastic Surgery
3288 Eagle View Lane Ste 300
Lexington, KY 40509
(859) 254-5665

www.WaldmanPlasticSurgery.com

HIPAA Information and Consent Form

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: _____

Waldman Schantz Plastic Surgery
3288 Eagle View Lane Ste 300
Lexington, KY 40509
(859) 254-5665
www.WaldmanPlasticSurgery.com

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Waldman Schantz Plastic Surgery
3288 Eagle View Lane Ste 300
Lexington, KY 40509
(859) 254-5665
www.WaldmanPlasticSurgery.com

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE **OPTIONAL** AND WILL BE KEPT **STRICTLY CONFIDENTIAL**.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) What is your current Height_____ and weight_____					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	How many drinks per week?					
Tobacco	Do you use tobacco or nicotine supplements?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day		☐ Nicotine Vapor - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No

Waldman Schantz Plastic Surgery
3288 Eagle View Lane Ste 300
Lexington, KY 40509
(859) 254-5665
www.WaldmanPlasticSurgery.com

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS
Father		
Mother		
Sibling	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	

MENTAL HEALTH

Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY (IF YOU ARE CONSIDERING BREAST OR ABDOMINAL SURGERY)

Number of children	Date of Last Delivery	Did you breast feed?	
Experienced any recent breast tenderness, lumps, or nipple discharge?		☐ Yes	☐ No
Have you had a mammogram?		☐ Yes	☐ No
Any family history of breast cancer?		☐ Yes	☐ No
If so, who?	How old were they when they were diagnosed?		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	