CARLO P. HONRADO MD, FACS
Board Certified Facial Plastic Surgeon

Intake Form

Name ____ DOB ______________ Age ______ ☐Male ☐Female

Marital Status _________________________________ Name of Spouse _____________________________________

Address ______________________________ City _________________________ State ______ Zip Code___________

Phone Numbers: Home ____________________ Cell ____________________ Work _________________________

Social Security Number _________________________ Driver's License __________________

Email ____ May we send you our newsletter: **Y N**

Employer _______________________________________ Occupation _____________________________________

How did you hear about Dr. Honrado? ☐Google ☐Yelp ☐RealSelf ☐Friend______________________________

☐other_____________________________ ☐Physician ____

INSURANCE

Insurance Company ______________________________________ ID Number _______________________________

Insured Name ____ Insured DOB ____________________

Primary Physician ____ Phone __________________________________

May we end your primary physician a report of our findings? __________

Emergency Contact ___________________________ Phone ____________________ Relationship________________

I authorize the release of medical information to my insurance company? ☐Yes ☐No

<u>BILLING POLICY:</u> Payment is expected at the time services are rendered.

The insurance company is hereby authorized to pay all benefits directly to my attending physician. If special arrangements for payments are needed, they must be made prior to services being rendered, please ask for the office manager.

I have read the above policy and understand my financial responsibility.

____ ______________________

Signature Date

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What is your activity level like? What types of things do you enjoy? Hobbies? ____

____

What's the reason for your visit?____

____

What are your goals with your visit?____

____

What are your concerns/fears?____

____

Areas of interest:

☐Botox ☐Juvederm ☐Restylane ☐Sculptra ☐Chemical Peel ☐Ulthera ☐Thermi

☐Rhinoplasty (nose job) ☐Blepharoplasty (eyelid surgery) ☐Otoplasty (ear pinning) ☐Facelift ☐Necklift

☐Browlift ☐Chin Augmentation ☐Latisse ☐Other ____

Skin:

☐Age Spots ☐Scarring ☐Laxity of Skin ☐Vessels ☐Pigmentation ☐Wrinkles

Current Medications: ____

Allergies to Medications: ____

Please list all prior major illnesses/surgeries with year of occurrence ____

____

Family History

☐Heart Disease ☐Diabetes ☐Cancer ☐Other ______________________________

Do you drink soda/coffee/tea?	☐No, never	☐No, but I used to	☐Yes	Cups/Drinks per day? _______
Do you drink alcohol?	☐No, never	☐No, but I used to	☐Yes	Drinks per? ______ day/week
Do you smoke?	☐No, never	☐No, but I used to	☐Yes	Packs per day? ___ x ___ yrs
Do you use illicit drugs?	☐No, never	☐No, but I used to	☐Yes	Which? __________________

Have you experienced any of the following? (circle yes or no)

Constitutional

weight gain/loss (>15lbs)	Y	N
constant night sweats	Y	N

Eyes

double vision	Y	N
glaucoma	Y	N

Ear/Nose/Throat

hearing loss	Y	N
ear pain	Y	N
ringing in ears	Y	N
balance problems	Y	N
hearing aid	Y	N
difficulty breathing	Y	N
nosebleeds	Y	N
nasal drainage	Y	N
sinus problems	Y	N
snoring	Y	N
voice changes	Y	N

Cardiovascular

heart attack	Y	N
high blood pressure	Y	N
Heart murmur	Y	N

Gastrointestinal

Diarrhea	Y	N
Heartburn	Y	N

Endocrine

Diabetes	Y	N
thyroid disease	Y	N
autoimmune disease	Y	N

Neurologic

Headaches	Y	N
Seizures	Y	N
stroke	Y	N

Hematology

bruise easily	Y	N
Anemia	Y	N

Genitourinary

frequent urination	Y	N
prostate problems n/a	Y	N

Skin

past skin cancer	Y	N
past radiation therapy	Y	N

Musculoskeletal

arthritis	Y	N
back pain	Y	N

Respiratory

asthma/emphysema	Y	N
chronic cough	Y	N
Tuberculosis	Y	N

Psychiatric

anxiety	Y	N
depression	Y	N
sleep problems	Y	N

Other

If yes to any of the above, please explain: ____

____

____

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CONSENT FOR PURPOSES OF TREATMENT AND HEALTHCARE OPERATIONS

I consent to the use of disclosure of my protected heath information by Carlo P. Honrado, MD, Inc. for the purposes of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of the Carlo P. Honrado, MD, Inc. I understand that the diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document. I understand that have the right to request a restriction as to how my protected heath information is used or disclosed to carry out treatment, payment or healthcare operations of the practice.

The Carlo P. Honrado, MD, Inc. is not required to agree to the restrictions that I may request. However, if the Carlo P. Honrado, MD, Inc. agrees to a restriction that I request, the restriction is binding on the Carlo P. Honrado, MD, Inc. and the rendering physician. I have the right to revoke this consent, in writing at any time, except to the extent that the Carlo P. Honrado, MD, Inc. has taken action in reliance on this consent. My "protected health information" means health information, including my demographics information collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to review the Carlo P. Honrado, MD, Inc.'s Notices of Privacy Practices prior to signing this document. The Carlo P. Honrado, MD, Inc.'s Notice of Privacy Policy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of the Carlo P. Honrado, MD, Inc. This Notice of Privacy Practices also describes my rights and the Carlo P. Honrado, MD, Inc.'s duties with respect to my protected health information. The Carlo P. Honrado, MD, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting in writing that a revised copy be sent in the mail or asking for one at the time of my next appointment.

____ _________________________

Signature of Patient or Personal Representative Date

Printed Name of Personal Representative ____

IN COMPLIANCE WITH NEW FEDERAL AND STATE REGULATIONS, THIS IS TO CONFIRM THAT I HAVE RECEIVED THE FOLLOWING DOCUMENTS:

A. Consent for purposes of treatment, payment and healthcare operations
B. Notice of Privacy Practices

____ ____________________________

Patient Signature Date

____ ____________________________

Witness Date