PLASTIC SURGERY
Michael Baroody, M.D.

Patient Information

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last/First/Middle

Address _____
Street & Apt # City State Zip

Preferred # Cell/Home/Work

Home # _____ Cell _____ Work _____ May we leave a message? Y / N

Birth Date _____ Age _____ Sex Male/Female E-mail _____

Marital Status _____ How did you hear about us? _____ Reason for visit? _____

Responsible Party
(If under 18 yo) _____
Last First Middle

Address _____ Home Phone _____
Street & Apt # City State Zip

Patient's Employer _____ Occupation _____

Address _____
Street & Suite # City State Zip

Primary Care Physician _____ **Referring Physician** _____

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Primary Health Insurance Company _____

Policy# _____ Group # _____ Referral Required? ☐Yes ☐No

Copay? ☐Yes ☐No $ _____ Subscriber Name: _____ DOB _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ Referral Required? ☐Yes ☐No

Copay? ☐Yes ☐No $ _____ Subscriber Name: _____ DOB _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Baroody to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Baroody and myself. I will be responsible for all costs incurred in order to collect the balance of my account including but not limited to collection agency fees, interest accrued, and attorney fees.

Patient Signature _____ **Date** _____

Please answer the following questions about your medical status and history

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc.)?
   ☐Yes ☐No If yes, please list _____
2. Have you ever had surgery? ☐Yes ☐No
   If yes, please list with dates_____

   _____
3. Do you take any prescribed or over the counter medications including supplements? ☐Yes ☐No
   If yes, please list_____

   _____
4. Women only: Birth Control? ☐Yes ☐No Are you pregnant? ☐Yes ☐No Trying? ☐Yes ☐No
5. Do you have any drug or food allergies? ☐Yes ☐No
   If yes, please list_____
   Reaction? (Circle all that apply) Hives/Itching/Anaphalactic Shock/Gastic Upset/Other

Review of Systems

Do you currently have any of the following problems?	Yes	No	If YES, describe
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems)	☐	☐	_____
Heart problems (e.g., chest pain, irregular heart beat)	☐	☐	_____
Respiratory problems (e.g. shortness of breath, wheezing, coughing)	☐	☐	_____
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea)	☐	☐	_____
Urinary problems (e.g., pain or discomfort, blood in urine)	☐	☐	_____
Skin problems (e.g. rashes, excessive dryness)	☐	☐	_____
Musculoskeletal problems (e.g., muscle aches, joint pain)	☐	☐	_____
Neurologic problems (e.g., numbness, weakness, headaches)	☐	☐	_____
Psychiatric problems (e.g., depression, anxiety)	☐	☐	_____
History of blood clots (e.g., pulmonary embolus, DVT)	☐	☐	_____

Family and Social History

Do any medical diseases run in your family? (e.g., diabetes, high blood pressure, cancer)
☐ Yes ☐ No If yes, please explain _____

_____

Do you smoke? ☐Yes ☐No If yes, how many packs per day? _____ How many years of smoking?____
Nicotine Patch, Gum, Chewing Tobacco ☐Yes ☐No

Do you drink alcohol? ☐ Yes ☐No If yes, how many drinks per week? _____

_____

∆ **M.D. Signature** ∆ **Date**

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AUTHORIZATION AND CONSENT TO PHOTOGRAPH AND PUBLISH

I authorize Dr. Michael Baroody to photograph or permit other individuals he may designate to photograph.

I hereby consent that photographs be taken of me by my physician or by a photographer approved by my physician. I understand these photographs will be used as part of a medical record and may be used for teaching or research purposes by my physician. Including any or all of the following:

1. Medical article or textbook
2. As a part of a scientific exhibit
3. To illustrate medical lectures given to medical students or other professional groups
4. To illustrate medical lectures given to the public
5. To illustrate articles appearing in lay publications on medical topics
6. To be used within the scope of my physician's practice to illustrate surgical results to other patients
7. To illustrate pre and postoperative surgical examples appearing on Dr. Michael Baroody's website and other websites Dr. Baroody participates with.

I understand that I will not be identified by name in any such use of these photographs.

I waive any right to compensation for the above uses. I hold the physician and his designees harmless from and against any claim for injury or compensation resulting from activities authorized by this agreement.

(☐) I accept the terms of this authorization.

Signature_____ Legal next of kin/Relationship_____

Date_____

Witness_____

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NOTICE OF PRIVACY PRACTICES

(203) 206-6901This notice describes how health information about you may be used and disclosed and how you can get access to this information. **PLEASE REVIEW IT CAREFULLY.**

We are required by law to maintain the privacy of protected health information and to provide individuals with the notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information and your rights with respect to this information.

USES AND DISCLOSED OF YOUR HEALTH INFORMATION:

TREATMENT: We may use medical information about you to provide you medical care. We disclose medical information to other physicians or other health care providers who will provide services which we do not provide. We may also share this information this information with a pharmacist who needs to dispense a prescription or laboratory that performs test.

PAYMENT: We may use and disclose medical information about you to your insurance company in order to obtain payment for the services we provide. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

HEALTHCARE OPERATIONS: We may use & disclose your health information in connection with the following:

1) To review and improve the quality of care we provide, or the competence and qualifications of our professional staff.
2) To request that your health plan authorize services and or referrals.
3) As necessary for medical reviews, legal services and audits; including fraud and abuse detection.
4) Compliance programs and business planning and management.
5) For clearing houses or health plans that have relationship with you when they request information to help them with their quality assessment and improvement activities, their efforts to improve or reduce healthcare costs.
6) For review of compliance, qualifications and performance of healthcare professionals, training programs, accreditations, and certification or licensing activities.

YOUR AUTHORIZATION: You may give us written authorization to use and disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or payment for your healthcare, but only if agree that we may do so. We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care. Your location, your general condition or death. You may revoke your authorization at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

REQUIRED BY LAW: We will use and disclose your health information, but we will limit this information to the relevant requirements of the law when the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceeding, or to law enforcement officials. We will further comply with the requirements set forth below concerning those activities.

1) Preventing or controlling disease, injury or disability.
2) Reporting child, elder, dependent adult abuse or neglect
3) Reporting domestic violence.
4) Reporting to the food and drug administration problems with products and reactions to medications.
5) Reporting disease or infection exposure
6) When we report suspected elder or dependent abuse or domestic violence, we will inform you or your personal representative promptly unless we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

NOTICE OF PRIVACY PRACTICES
Patient:

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

Signature Date

Baroody Plastic Surgery

Cosmetic Interest Questionnaire

Name: _____ **Date:** _____

Phone: _____ **E-mail:** _____

At Baroody Plastic Surgery, we are constantly striving to offer you the safest, most advanced procedures available. Please review the following and check the boxes that relate to you.

What are your areas of concern?

Face & Neck:

- ☐ Frown lines between the eyebrows
- ☐ Fine lines and wrinkles
- ☐ Rough skin texture/Acne
- ☐ Facial pigmentation problems/Age Spots
- ☐ Facial hair
- ☐ Loss of volume in your cheeks
- ☐ Loose skin of the face/neck
- ☐ Sagging eyelids
- ☐ Size/shape of your nose
- ☐ Lack of fullness in your lips
- ☐ Short eyelashes
- ☐ Other, please specify _____

Body:

- ☐ Extra abdominal fat
- ☐ Extra skin of the abdomen
- ☐ Extra fat of arms/legs
- ☐ Sagging breasts
- ☐ Desire for smaller breasts
- ☐ Desire for larger breasts
- ☐ Spider veins
- ☐ Other, please specify _____

Are you interested in learning more about the following?

- ☐ Botox® Cosmetic
- ☐ Alpha hydroxyl acid and glycolic peels
- ☐ Laser skin resurfacing and laser treatments
- ☐ Removal of liver spots/age spots
- ☐ Spider vein removal
- ☐ Skin rejuvenation
- ☐ Facial fillers
- ☐ Retin-A or Renova
- ☐ Hair removal
- ☐ Facial or leg vein removal
- ☐ Chemical peels
- ☐ Scar revision

Other, please specify _____