Attached you will find demographic and medical information forms. It is **very important** that you fill out this paperwork ***in its entirety*** (do not leave pages blank) and bring it to your appointment a few minutes prior to your appointment time. This will prevent your appointment being delayed or inconvenience to patients being seen after you.

Please write **legibly** and **PRINT** so that we can accurately transfer the information into the computer.

INFORMATION FOR CASE HISTORY FILE

(PLEASE complete all items, PLEASE print or type)

Today's Date_____

Mrs. □ Miss □ Mr. □ Ms. □ Married □ Single □ Divorced □ Separated □ Widowed □ SS#_____

Patient's Name_____ Age_____ Date of Birth_____

Home Address_____City_____State_____Zip _____

Home Phone_____ Cell Phone_____ Email_____

Patient's Occupation_____ Employer _____

Business Address_____ Business Phone_____ Ext._____

Name of Spouse_____ Spouse's Occupation_____

Spouse's Employer_____ Address_____ Business Phone_____

Patient Referred by_____ Address_____ Phone_____

Family Doctor_____Address_____Phone_____

Emergency Contact _____Phone No._____

Insurance Company_____ Group No._____ Policy No._____

Address of Insurance Co._____

Through what company or employer? _____

SS# of Card Holder_____ Group No._____ Birth Date of Card Holder_____

If person completing form is someone other than patient, or if the patient is a minor, please complete the following:

Name_____ Relationship_____
(Party financially responsible)

Address_____
(Street) (City) (State) (Zip)

Occupation_____ Employer_____

Business Address_____ Business Phone_____

Specific problem(s) for which you are seeking plastic surgery:_____

Have you consulted any other doctors, including plastic surgeons, about this? No_____ Yes_____

If yes, please list their name(s):_____

Release of Information

May we leave a message at your home with other residents? Yes_____ No____

May we leave a message on your answering machine/voice mail? Yes_____ No____

Whom may we speak with about your medical concerns?

Name: _____Relationship: _____Phone No. _____

Is this contact for emergencies only? Yes_____ No____

Can they be contacted about your general care? Yes_____ No____

FAMILY HISTORY

Fill in the following information about your family:

Check if any of your relatives have had the following:

Relation	Age	State of Health	Age at Death	Cause of Death		Disease	Relationship To You
Father						Diabetes	
Mother						Heart Disease	
Brothers						Cancer	
						High Blood Pressure	
						Stroke	
						Arthritis	
Sisters						Asthma	
						Chemical Dependency	
						Kidney Disease	
						Other	

MEDICATIONS, DRUGS

Are you allergic to any medicines? ☐ No ☐ Yes

If "Yes," which one(s)? _____

Please list ALL of your medications and their dosages (including VITAMINS, BIRTH CONTROL PILLS, DIURETICS (water pills), BLOOD PRESSURE or HEART MEDICATIONS, TRANQUILIZERS, HORMONES, BLOOD THINNERS, NOSE DROPS and SPRAYS, INHALER MEDICINES, RUB-ON MEDICATIONS (liniments), ASPIRIN, BUFFERIN, ETC.)

_____ _____

_____ _____

_____ _____

PAST MEDICAL HISTORY

General Health: ☐ Good ☐ Fair ☐ Poor

If not "Good," please explain:

_____

Height_____ Weight_____ Weight loss or gain in past year _____lb. ☐Loss ☐Gain

How long ago was your most recent physical check-up? _____

Name and address of the doctor _____
(Name) (Address)

Did it include an electrocardiogram? ☐ No ☐ Yes
Did it include a chest X-ray? ☐ No ☐ Yes

History of Raynaud's Disease or Cold Intolerance? ☐ No ☐ Yes _____

Serious Illnesses (Please List) _____

_____

_____

_____

Previous Surgery (Please List)

Operation	Year	Hospital	City	Surgeon's Name	Anesthesia (Local or General)

_____

_____

_____

_____

_____

_____

Have you had significant complications or aftereffects from any of these operations? ☐ No ☐ Yes

If "Yes,"
Please explain: _____

_____

_____

_____

_____

INJURIES

Type of Injury	Year	Hospital	Doctor	After-Effects

_____

_____

_____

_____

SOCIAL HISTORY

What is your approximate daily consumption of the following: Coffee/Tea _____ cups per day / week / month?

Alcohol _____ drinks per day / week / month Tobacco _____ # of times per day

Are there other smokers in the house? ☐ No ☐ Yes How much? _____

Other intoxicating or mind altering drugs (specify): _____

PREOPERATIVE INFORMATION

Have you ever reacted badly to being put to sleep for surgery? ..... ☐ No ☐ Yes

Has any member of your family ever reacted badly to being put to sleep for surgery? ☐ No ☐ Yes

Have you required unusually large amounts of local anesthetic for medical or dental procedures? ☐ No ☐ Yes

Have you ever had a bad reaction to a local anesthetic (Novocain, etc.)? ..... ☐ No ☐ Yes

Are you allergic to adhesive tape? ..... ☐ No ☐ Yes

Do you have high blood pressure? ..... ☐ No ☐ Yes

Have you ever had scarlet fever or rheumatic fever? ..... ☐ No ☐ Yes

Do you bleed unusually easily (from cuts, surgery, or tooth extractions)? ..... ☐ No ☐ Yes

Are you a slow or poor healer? ..... ☐ No ☐ Yes

Do you form large scars or keloids? ..... ☐ No ☐ Yes

Do you have any skin disease, hives, eczema, or rash? ..... ☐ No ☐ Yes

Do you have frequent infections or boils? ..... ☐ No ☐ Yes

Have you taken steroid medications, cortisone, or ACTH? ..... ☐ No ☐ Yes

Do you have shortness of breath with walking? ..... ☐ No ☐ Yes

Do you have, or have you had any back trouble? ..... ☐ No ☐ Yes

Does your religion prohibit blood transfusions? ..... ☐ No ☐ Yes

Do you have, or have you had any significant emotional problems? ..... ☐ No ☐ Yes

Have you ever been advised to seek psychiatric care? ..... ☐ No ☐ Yes

Have you had any illnesses or disorders of the following? (Check if Yes)

☐ Brain (including strokes, epilepsy)
☐ Blood
☐ Nervous System
☐ Urinary System
☐ Intestines
☐ Ears
☐ Face (including paralysis)
☐ Arms or Legs
☐ Nose, Sinuses, Throat
☐ Eyes (including glaucoma, dryness)
☐ Reproductive System
☐ Lungs (including asthma)
☐ Heart or blood vessels
☐ Bones or Joints
☐ Stomach
☐ Breasts
☐ Endocrine System (diabetes)
☐ Liver

If "Yes,"
Please explain: _____

_____

_____

_____ _____ _____

Signature Relationship to Patient (Self, Mother, etc.) Date

University Hospitals
Case Medical Center

PHOTOGRAPHIC RELEASE AND CONSENT

BAHMAN GUYURON, MD, DEPARTMENT CHIEF

JASON GANZ, MD
ARUN GOSAIN, MD
DAVID ROWE. MD
HOOMAN SOLTANIAN, MD
DAVID STEPNICK, MD
ELLIOTT CHEN. MD

University Hospitals
Zeeba Surgery Center

I understand that photographs will be taken during my visit. I accept that I may be recognized from my likeness or case history. Nevertheless, I authorize my plastic surgeon to use my photographs, videotapes and case information in the settings that I have checked:

- ❑ Lectures and multi-media presentations for an audience of medical professionals
- ❑ Medical, surgical, and scientific journal articles and publications
- ❑ My surgeon's file of pre and postoperative patient photographs available to prospective patients for viewing in the office
- ❑ For office and surgical use only
- ❑ Newspaper and magazine articles in which my surgeon participates
- ❑ Television programs in which my surgeon participates
- ❑ My surgeon's personal web site or web page
- ❑ Lectures and multi-media presentations given by my surgeon for the general public
- ❑ For use by the ABPS (American Board of Plastic Surgery)

I also authorize my plastic surgeon's professional association, the not-for-profit American Society for Aesthetic Plastic Surgery, to use my photographs and case information in fulfilling its mission of public education, in the settings that I have checked:

- ❑ Patient education brochures available for purchase
- ❑ Educational video tapes available for purchase
- ❑ Lectures and slide presentations available for purchase
- ❑ Information submitted by the Society to consumer periodicals and magazines for publication
- ❑ Television programs about plastic surgery
- ❑ Case studies presented on the Society's web site at www.surgery.org

_____ _____
Patient Signature Date

_____ _____
Print Name

_____ _____
Witness Signature Date

_____
Print Name

The consent provided in this document shall be valid immediately and until such time as the patient affirmatively withdraws, in a writing addressed to University Hospitals Department of Plastic Surgery, the consent provided herein. Such withdrawal shall be effective upon its receipt by University Hospitals Department of Plastic Surgery.

University Hospitals
Case Medical Center

Consent Form

University Hospitals Medical Group

I. Authorization for Treatment

Patient/patient's legal representative, agree to permit performance of such diagnostic, evaluation and therapeutic procedures that the physician(s) deems necessary for my treatment and care.

II. Authorization to Release Information

The undersigned hereby permits University Hospitals Medical Group, its physicians, affiliated health care providers, and/or their authorized personnel to access and/or release all of any part of the patient information (including information regarding substance abuse, HIV testing, AIDS and psychiatric treatment) to, including but not limited to, the appropriate healthcare insurer(s), employers for work-related injuries, third party payors and/or the Physicians' agent(s), attorney(s) and/or consultant(s) for purposes including treatment of the patient, billing (or collecting payment) for services and healthcare operations including improving patient care, performance improvement initiatives, risk management and/or as required by law.

I further understand that such information will be available to other University Hospitals Health System entities as may be necessary for the completion of claims for reimbursement to the appropriate health care insurer, agency or any third party which may be liable for charges.

III. Assignment of Benefits

In consideration of services received, I assign the benefits payable for services rendered to the physician(s) or designated agents. I direct those insurers to pay such benefits directly to the physician(s) or designated agents. I agree to pay any and all fees that exceed or that are not covered by my insurance coverage and waive any and all notices and demands in the event of non-payment

[If applicable]: I am aware that I am choosing to utilize a health care provider that is *not in network* with my insurance plan. Therefore, I accept financial responsibility for the out of network penalty determined by my insurance company.

_____ (patient's initials)

IV. Medicare/TRICARE/Champus Payment/NOPP

I certify that the information I gave if applying for payment under Title XVII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (including TRICARE/Champus/Humana Military Claims.) I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician(s) or their designated agents, or authorize such physician(s) or designated agents to submit a claim to Medicare for payment to me.

I acknowledge receipt of a copy of the Notice of Privacy Practices: ____Yes ____No

If not, reason for acknowledgement not received _____

V. Certification

I certify that to the best of my knowledge and belief, the information provided is complete and correct. This assignment and consent is valid from the date of signature. I understand that this consent is subject to revocation by me at any time except if the person or entity authorized to make a disclosure has already acted in reliance to this form. Other wise, subject to applicable law, this consent will expire at the same time that the Physician(s)' record retention period for this document expires. This notice must be received prior to release of information.

I AM THE PATIENT OR REPRESENTATIVE AUTHORIZED TO SIGN THIS DOCUMENT. I HAVE READ THE ABOVE AND UNDERSTAND ITS TERMS.

_____ _____

Signature of Patient/or Legal Representative (Indicate relationship) Social Security Number

_____

Print Name of Patient/Legal representative

_____

Date

Revised March 2007

Department of Plastic Surgery
University Hospitals of Cleveland

Notice of Privacy
THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction
At University Hospitals of Cleveland, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective January 1, 2006 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information
Each time you visit University Hospitals of Cleveland, a record of your visit is made.
Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:
• Basis for planning your care and treatment,
• Means of communication among the many health professionals who contribute to your care,
• Legal document describing the care you received,
• Means by which you or a third-party payer can verify that services billed were actually provided,
• A tool in educating heath professionals,
• A source of data for medical research,
• A source of information for public health officials charged with improving the health of this state and the nation,
• A source of data for our planning and marketing,
• A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve. Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others

Your Health Information Rights
Although your health record is the physical property of University Hospitals of Cleveland, the information belongs to you. You have the right to:
• Obtain a paper copy of this notice of information practices upon request,
• Inspect and copy your health record as provided for in 45 CFR 164.524,
• Amend your health record as provided in 45 CFR 164.528,
• Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
• Request communications of your health information by alternative means or at alternative locations,
• Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
• Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities
University Hospitals of Cleveland, is required to:
• Maintain the privacy of your health information,
• Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
• Abide by the terms of this notice,
• Notify you if we are unable to agree to a requested restriction, and
• Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain.

Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will e-mail the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem
If have questions and would like additional information, you may contact the practice's Privacy Officer, Mary Bongiorno, at (440)461-7999.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services.

There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations. We will use your health information for treatment.
For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.
For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record.

When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with law relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.