

PATIENT INFORMATION FORM

Please Print

PATIENT NAME: _____ DATE: _____
 ADDRESS: _____ BIRTHDATE: _____
 CITY: _____ STATE: _____ ZIP: _____
 AGE: _____ SEX: M () F () MARITAL STATUS: () MARRIED () SINGLE () DIVORCED () WIDOWED
 SOCIAL SECURITY #: _____ FAMILY DOCTOR: _____
 RESPONSIBLE PARTY IF DIFFERENT FROM ABOVE: _____
 ADDRESS: _____ PHONE: _____
 EMPLOYER: _____ OCCUPATION: _____ PHONE: _____
 NEAREST FRIEND OR RELATIVE: _____ PHONE: _____
 REFERRED BY: _____ PERSONAL CELL. PHONE: _____
 E-MAIL ADDRESS: _____ OTHER PHONE: _____

ARE YOU INTERESTED IN FINANCING: YES () NO ()

HOW WILL YOU PAY FOR TODAY'S VISIT? Cash () Check () Credit Card ()

ARE YOU INTERESTED IN SKIN CARE, BOTOX, FILLERS? YES () NO ()

HEALTH HISTORY (PLEASE ANSWER ALL QUESTIONS)

WHAT WOULD YOU LIKE DR. GENTILE TO HELP YOU WITH?

DOES YOUR CONCERN ABOUT YOUR APPEARANCE PREVENT YOU FROM DOING CERTAIN ACTIVITIES? (SUCH AS GOING TO PARTIES, ETC.) _____

WHEN DOES IT BOTHER YOU THE MOST? _____

ON A SCALE FROM 1-10, COMPARED TO THE REST OF THE POPULATION

How do you rate your overall attractiveness? (1-10) _____ (1=least and 10=best)

How do you rate your area of concern? (1-10) _____ (1=least and 10=best)

YES NO Do you think plastic surgery can turn your life around? (If yes, explain) _____

YES NO Have you ever consulted a plastic surgeon? (Please give details, if you wish to.)

YES NO Have you had any plastic surgery? (Please describe, including dates.)

YES NO Were you satisfied with the results of any plastic surgery you may have had?

PLEASE SEE NEXT PAGE!

Revised 1/5/10

Have you ever had any of the following in the skin of the face, eyelids, scalp, or neck:

Dermabrasion, Laser, Chemical Peels
 Oral Herpes
 Loss of Hair
 Acne
 Scars, Moles, Rashes, other skin lesion
 Radiation Treatment
 Skin Cancer

Please list any surgery you have had. (ex.: Hernia, T & A, C-section, D & C, laparoscopy, Appendectomy, etc)

Please describe any hospital admission. (ex. Pneumonia, Diabetes)

YES NO Have you ever had any dental procedure complications? If yes, please describe:

YES NO Do you heal well?

YES NO Do you bruise easily?

YES NO Do you scar badly?

Please describe your health:

Weight _____

Height _____

YES NO Do you have High Blood Pressure?

YES NO Have you had Anemia (low blood counts)? Have you ever had an episode of Syncope (passing out)? Does anybody in your family have Anemia?

YES NO Have you ever had an irregular heartbeat?

YES NO Have you ever had a heart attack?

YES NO Have you had "Angina" (pain in the chest with exertion), or Pleuritic pain?

YES NO Have you ever taken heart medicines or high blood pressure medicines? (If yes Please list.) _____

YES NO Do you become short of breath easily? Have you ever had an episode of difficulty breathing!

YES NO Do you have: Asthma Sleep Apnea Bronchitis Emphysema

YES NO Do you snore or fall asleep easily during the day?

YES NO Do you wake up during the night with choking sensation?

YES NO Have you ever had any Collagen Diseases? (ex. Lupus, Rheumatoid Arthritis)

YES NO Have you ever had a "Stroke"?

YES NO Have you ever had any Nervous System Problems? Seizures or Epilepsy?

What medications do you take now?

Medication	Dosage	Frequency	Purpose

YES NO

Are you, or have you ever taken:

- | | | |
|--|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Other Hormones | <input type="checkbox"/> Other Antibiotics |
| <input type="checkbox"/> Advil/Motrin | <input type="checkbox"/> Valium | <input type="checkbox"/> Novacaine |
| <input type="checkbox"/> Ephedra | <input type="checkbox"/> Librium | <input type="checkbox"/> Xylocaine |
| <input type="checkbox"/> Accutane | <input type="checkbox"/> Steroids | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Green Tea, Gingko | <input type="checkbox"/> Tylenol | <input type="checkbox"/> Keflex |
| <input type="checkbox"/> Garlic | <input type="checkbox"/> Codeine, Percodan/cet | <input type="checkbox"/> "Bete Blockers" |
| <input type="checkbox"/> Herbs of any sort | <input type="checkbox"/> Demoral, Morphine | <input type="checkbox"/> Diuretics |
| <input type="checkbox"/> Diet Pills | <input type="checkbox"/> Anti-Depressants | <input type="checkbox"/> Marine Omega-3 Fatty Acids |
| <input type="checkbox"/> Female Hormones | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Other Fish Oil Supplements |
| <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Inderal, Verapamil | <input type="checkbox"/> Calcium Channel Blockers |

YES NO

Have you ever had a bad reaction or an allergic reaction to any medication? or adhesive tape? (Please describe reaction from which medication.)

YES NO

Are you allergic to iodine shellfish, shrimp, oysters, avocados, kiwi or bananas?

YES NO

Have you or any family member ever had reaction or allergy to anesthesia?

YES NO

Is there a history of blood clots or pulmonary embolism in you or your family?

YES NO

Do you, or have you ever used any drugs for recreational purposes?

- | | | |
|------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Cocaine/Crack | <input type="checkbox"/> LSD/Acid |
| <input type="checkbox"/> Heroin | <input type="checkbox"/> Other _____ | |

YES NO

Do you smoke? How long? _____ How many per day? _____

YES NO

Please describe your alcohol consumption? _____ glasses/cans of _____ per day _____ per week

YES NO

How many pregnancies have you had? _____ How many alive? _____

YES NO

Are there any other details or medical conditions that you have not mentioned that you feel are pertinent and if so, please describe:

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and had an opportunity to read the office's Notice of Privacy Practice's, which explains how my medical information will be used and disclosed. In reading this information, I understand my rights as a patient and also I understand that I am entitled to receive a copy of this document.

If it is necessary for Dr. Gentile or his staff to notify me of personal health information, I wish to be contacted in the following manner (check all that apply):

- Home Telephone (____)_____ Written Communication
- O.K. to leave message with detailed information Ok to mail to my home address
- Leave message with call back number only Ok to Email or fax: _____

- Work Telephone (____)_____ Cellular Phone (____)_____
- O.K. to leave message with detailed information Ok to leave message on voice mail
- Leave message with call back number only

Personal health information may be released to the following nearest friend or relative(s):

Name: _____ Name: _____

Telephone: (____) _____ Telephone: (____) _____

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative (Please Print)

Description of Personal Representative's Authority

Yes By checking the box Yes, you give consent and thereby permission to receive our email newsletter.
My email address is: _____

Initials

CONSENT TO PHOTOGRAPHS

I hereby authorize and give permission to Dr. Gentile and/or his assistants to take such photographs of me as he may desire before, during, and after treatment.

Signature of Patient

MUTUAL AGREEMENT TO MAINTAIN PRIVACY

Dr. Herve Gentile and A Better You Cosmetic Surgery Center (collectively labeled “Physician”) agree to maintain Privacy of _____ (patient name) as outlined in the HIPAA form. Dr. Herve Gentile takes pride in being able to extend a greater degree of privacy than is required by HIPAA, state confidentiality mandates, and common law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, HIPAA forbids physicians from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physicians believe this is improper and may not be in the patients’ best interest. Accordingly, Dr. Gentile agrees not to provide any list for marketing directly to patients. Regardless of legal privacy loopholes, Dr. Gentile will never attempt to leverage its relationship with Patient by seeking Patient’s consent for marketing products for others.

In consideration for treatment and the above noted patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Physician and his practice, expertise and/or treatment- the sole exceptions being communication to a confidential medical-peer review body; to another healthcare provider; to a licensed attorney; to a governmental agency; in the context of a legal proceeding; or unless mandated by law. Publishing is intended to include attribution by name, by pseudonym or anonymously. If Patient does prepare commentary for publication about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment is in further consideration for additional privacy protections provided by Physician. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary. Physician has invested significant financial and marketing resources in developing the practice. In addition, Patient will not denigrate, defame, disparage, or cast aspersions upon the Physician, and (ii) will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in any such activity. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage a Physicians practice.

Physician feels strongly about Patients’ privacy as well as the practices’ right to control its public image and privacy. Both Physician and Patient will work to prevent the publishing or airing of commentary about the other party from being accessed via Internet, blogs, or other electronic, print, or broadcast media without prior written consent. Finally, this Agreement shall be in force and enforceable (and fully survive) for a period of the longer of (a) five years from Physician’s last date of service to Patient; or (b) three years beyond any termination of the Physician-Patient relationship. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician’s patients.

Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

SO AGREED THIS _____ DAY OF _____, 200_____.

(patient signature)

Herve’ F. Gentile, MD
A Better You Cosmetic Surgery Center

(printed name)