

# CHRYSLIS COSMETICS

## PATIENT INFORMATION

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: [First] \_\_\_\_\_ [M.I.] \_\_\_\_\_ [Last] \_\_\_\_\_  Male |  Female  
Address: \_\_\_\_\_ [Apt.] \_\_\_\_\_ Age: \_\_\_\_\_ D.O.B: \_\_\_\_/\_\_\_\_/\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Drivers License #: \_\_\_\_\_ Home Tel: \_\_\_\_\_  
Work Tel: \_\_\_\_\_  
Mobile Tel: \_\_\_\_\_  
E-mail: \_\_\_\_\_@\_\_\_\_\_

## EMPLOYMENT INFORMATION

Full Time |  Part Time |  Student |  Retired |  Other Occupation: \_\_\_\_\_  
Employer/School: \_\_\_\_\_ Work Tel: \_\_\_\_\_

## EMERGENCY CONTACT

Name: [First] \_\_\_\_\_ [Last] \_\_\_\_\_ Home Tel: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Work Tel: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Tel: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## REFERRAL INFORMATION

Referring Physician/Patient/Source: \_\_\_\_\_  
How did you hear about Dr. Perry? \_\_\_\_\_  
Have you been to our website [www.SacramentoPlastics.com]?  Yes |  No

## PROCEDURE INFORMATION

What is the reason for your visit today? [Check all applicable procedures below]

FACE	BREAST	BODY	SKIN
<input type="checkbox"/> Facelift	<input type="checkbox"/> Breast Augmentation	<input type="checkbox"/> Liposuction	<input type="checkbox"/> Botox Cosmetic
<input type="checkbox"/> Cheek Lift	<input type="checkbox"/> Breast Lift (Mastopexy)	<input type="checkbox"/> Tummy Tuck	<input type="checkbox"/> Facial Fillers
<input type="checkbox"/> Brow Lift	<input type="checkbox"/> Breast Revision / Repair	<input type="checkbox"/> Mommy Makeover	<input type="checkbox"/> Fat Injections
<input type="checkbox"/> Neck Lift	<input type="checkbox"/> Breast Implant Exchange	<input type="checkbox"/> Body Lift	<input type="checkbox"/> Skin Resurfacing
<input type="checkbox"/> Liquid Facelift	<input type="checkbox"/> Breast Capsulectomy	<input type="checkbox"/> Buttock Augmentation	<input type="checkbox"/> Skin Tightening Laser
<input type="checkbox"/> Facial Fat Transfer	<input type="checkbox"/> Breast Reduction	<input type="checkbox"/> Arm Lift (Brachioplasty)	<input type="checkbox"/> Hand Rejuvenation
<input type="checkbox"/> Facial Implants	<input type="checkbox"/> Breast Asymmetry	<input type="checkbox"/> Thigh Lift	<input type="checkbox"/> Hyperhidrosis
<input type="checkbox"/> Lip Augmentation	<input type="checkbox"/> Male Breast Surgery	<input type="checkbox"/> Fat Transfer	<input type="checkbox"/> Skin Care
<input type="checkbox"/> Chin Augmentation	Other: _____	Other: _____	Other: _____
<input type="checkbox"/> Ear Reshaping	_____	_____	_____
<input type="checkbox"/> Upper Eyelids			
<input type="checkbox"/> Lower Eyelids			
<input type="checkbox"/> Rhinoplasty			
Other: _____			

Please describe why you are interested in having the procedure(s) listed above: \_\_\_\_\_

Have you consulted with other physicians about procedure(s) indicated above?  Yes |  No

Is this procedure a revision from a previous surgery?  Yes |  No If yes, how many \_\_\_\_\_

**SURGERY SCHEDULING QUESTIONNAIRE**

To help us understand your needs and time preferences for your surgery, please provide us with the following information:

What is your time preference for your Procedure? Within the next: 1 Month | 3 Months | 6 Months | 1 Year

**HEALTH INFORMATION**

Primary Care Physician: \_\_\_\_\_ Other Physicians: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

**PERSONAL MEDICAL HISTORY**

Do you have any chronic medical problems? [Fill in box for those that apply]

- High Blood Pressure    Diabetes    Heart Disease    Kidney Disease    Stroke    Heart Failure
- Stomach Problems    Seizures    Liver Disease    Bleeding Problems    Emphysema    Cancer
- Heart Attack    Hepatitis    Chest Pain    Gastric Reflux    Asthma    HIV or AIDS
- Psychiatric Diagnosis    Other: \_\_\_\_\_

Is there a personal or family of anesthetic complications or malignant hyperthermia?  Yes | No

If yes, please explain? \_\_\_\_\_

**FAMILY HISTORY**

Do you have a family history of any medical problems? \_\_\_\_\_

Please indicate Family member(s): \_\_\_\_\_

Please list all prior Operations/Hospitalizations:

Date

List any complications:

- |          |                |       |
|----------|----------------|-------|
| 1. _____ | ____/____/____ | _____ |
| 2. _____ | ____/____/____ | _____ |
| 3. _____ | ____/____/____ | _____ |

Please list ALL CURRENT medications and/or dietary supplements including: (Prescriptions, Over the Counter Medicines, Aspirin, Vitamins, and Herbal Supplements)

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

Please list ALL allergies and describe reactions: (i.e. Shellfish, Latex, Penicillin, etc.) \_\_\_\_\_

**SOCIAL HISTORY**

Do you use Blood Thinners? (i.e.Coumadin/Heparin/Ibuprofen)  Yes |  No If Yes, medication name: \_\_\_\_\_

Have you used Diet Pills in the last two (2) weeks?  Yes |  No If Yes, medication name: \_\_\_\_\_

Have you taken Steroids / Accutane within the last year?  Yes |  No If Yes, medication name: \_\_\_\_\_

Have you ever smoked tobacco/Hookah/Vape products?  Yes |  No If Yes, How many/how long: \_\_\_\_\_  
If you quit, when? \_\_\_\_\_

Do you use Recreational Drugs?  Yes |  No If Yes, list type: \_\_\_\_\_

**FEMALE QUESTIONNAIRE**

Female Gynecological History: Have you had had any previous pregnancies?  Yes |  No # \_\_\_\_\_

Do you plan on having any or any more children?  Yes |  No

Have you had a mammogram in the last year? If yes, date of exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Normal or Abnormal

**GETTING TO KNOW YOU:**

How might this procedure change your life? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What would surgery allow you to do more of, that you haven't done? \_\_\_\_\_

\_\_\_\_\_

Who are your life influencers? \_\_\_\_\_

\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

At Chrysalis Cosmetics your privacy is a very important part of our mission and confidentiality is a very big factor in your experience. Dr. Perry and his staff adhere to the highest standards of respecting and protecting patient privacy and the confidentiality of your health care information. Additionally, the team complies with all state and federal regulations regarding the privacy of individual health care information, including HIPPA (Health Care Insurance Privacy and Protection Act), enacted on April 14, 2003. We are required by law to have available, a copy of the "Notice of Privacy Practices" regarding your Personal Health Information (PHI).

Your PHI, also known as your health or medical record, serves as a:

- Basis for planning your care and treatment and post-surgical care
- 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 provided
- A tool in educating health 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 tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

The "Notice of Privacy Practices" details the following:

- How we may use/disclose your PHI to carry out treatment, payment, or health care operations.
- How you may request copies of your healthcare information.
- How you may verify the accuracy of this information.
- How you may request an accounting of certain external disclosures of your PHI.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax, email, mail, or phone.

**Please acknowledge that you fully understand and accept the terms of "Notice of Privacy Practices" by signing below:**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

List of HIPAA approved individuals to aid in my care: \_\_\_\_\_

\_\_\_\_\_