CHRYSALIS COSMETICS

PATIENT INFORMATION Date: _____/_____/_____

Name (Legal): [First] _____ [Nick Name]: _____ [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
☐ Facelift	☐ Breast Augmentation	☐ Liposuction	☐ Botox Cosmetic
☐ Cheek Lift	☐ Breast Lift (Mastopexy)	☐ Tummy Tuck	☐ Facial Fillers
☐ Brow Lift	☐ Breast Revision / Repair	☐ Mommy Makeover	☐ Fat Injections
☐ Neck Lift	☐ Breast Implant Exchange	☐ Body Lift	☐ Skin Resurfacing
☐ Liquid Facelift	☐ Breast Capsulectomy	☐ Buttock Augmentation	☐ Skin Tightening Laser
☐ Facial Fat Transfer	☐ Breast Reduction	☐ Arm Lift (Brachioplasty)	☐ Hand Rejuvenation
☐ Facial Implants	☐ Breast Asymmetry	☐ Thigh Lift	☐ Hyperhidrosis
☐ Lip Augmentation	☐ Male Breast Surgery	☐ Fat Transfer	☐ Skin Care
☐ Chin Augmentation	Other: _____	Other: _____	Other: _____
☐ Ear Reshaping	_____	_____	_____
☐ Upper Eyelids			
☐ Lower Eyelids			
☐ 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 QUESTIONAIRE

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: _____

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

_____

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. _____

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? _____

****Disclaimer: If you are a smoker, MUST DISCONTINUE 4 weeks BEFORE&AFTER SURGERY, Nicotine Test Administered****

Do you use Recreational Drugs? □ Yes | □ No If Yes, list type: _____

FEMALE QUESTIONNARE

Female Gynecological History: Have you had any previous pregnancies? □ Yes | □ No #_____ of live births

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: _____

_____