SALZMAN
COSMETIC SURGERY AND SPA

Today's Date: ___________________________

PATIENT INFORMATION

Name:			Nickname:
Address:			
City:	State:	Zip:	Sex (Circle One): M or F
Date of Birth:	Age:	Social Security #:	
Cell #:	Can we text?: Y or N	Home #:	
Email:			
Patient's Employer:		Work #:	
Occupation:			

We cannot share any information without your consent!

Emergency Contact #1 Name:	Relationship to Patient:
Emergency Contact #1 Phone Number:	
Info allowed to share with contact #1 **(Circle One)**: Any/All * Financial * Health Care * Appointments	

Emergency Contact #2 Name:	Relationship to Patient:
Emergency Contact #2 Phone Number:	
Info allowed to share with contact #2 **(Circle One)**: Any/All * Financial * Health Care * Appointments	

How did you hear about us:
Reason for Visit:

How soon are you wanting surgery (Circle One)? ASAP * 6-8 weeks * 6 months - Year

Below are lists of the various concerns and treatments that we offer our patients. Please circle any area in which you are interested in learning more about.

Non-Surgical Concerns:

- Acne/ Acne Scars
- Aging Hands
- Body Tension
- Brown/Red Spots
- Cellulite
- Crepey Skin
- Dark Circles
- Excessive Sweat
- Facial Volume Loss
- Facial/Leg Veins
- Fine Lines
- Freckles
- Hair Loss
- Hyperpigmentation
- Large/Clogged Pores
- Lip Enhancement
- Melasma
- Milia
- Oily Skin
- Port Wine Stains
- Sagging Skin
- Scarring
- Skin Dryness
- Skin Texture
- Spider Veins
- Stubborn Fat
- Sun Damage
- Thinning Brows/Lashes
- Unwanted Hair
- Unwanted Tattoo
- Wrinkles

Feminine Concerns:

- Overactive Bladder
- Painful Sex
- Stress Urinary Incontinence
- Vaginal Atrophy
- Vaginal/Anal Pigment Correction

Cosmetic Gynecology:

- Clitoral Hood Reduction
- Core Intima Laser
- Labiaplasty
- O-Shot
- Perineoplasty
- Vaginoplasty

Surgical Options:

- Arm Reduction
- Body Lift
- Breast Augmentation
- Breast Lift
- Breast Reduction
- CelluSmooth
- Chin Implant
- Ear Pinning
- Eyelid Lift
- Facelift/Mini Facelift
- Fat Injections
- Laser Resurfacing
- Lip Lift
- Liposuction
- Rhinoplasty
- ThermaTyte
- Thigh Lift
- Tummy Tuck

If time permits, would you be interested in seeing a Skin Care Specialist or Massage Therapist today? Yes or No

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HEALTH HISTORY

Patient Name:

Height:	Weight:

Review of Your Body Systems: Do you have now or have you ever had any of the following? Please Circle Yes or No			
ADHD	Yes or No	Anxiety	Yes or No
Anemia	Yes or No	Asthma	Yes or No
Arthritis	Yes or No	Blood Transfusions	Yes or No
Auto-immune Disease	Yes or No	Brain Injury	Yes or No
Blood Clots	Yes or No	Cancer and Type	Yes or No
Breast Disease	Yes or No	Coronary Artery Disease	Yes or No
Congestive Heart Failure	Yes or No	Emphysema/COPD	Yes or No
Depression	Yes or No	Excessive Bleeding	Yes or No
Diabetes	Yes or No	Gastric Reflux	Yes or No
Epilepsy	Yes or No	Hernia/Peptic Ulcer	Yes or No
Gall Bladder	Yes or No	Heart Disease	Yes or No
Glaucoma	Yes or No	Hepatitis	Yes or No
Headache/Migraine	Yes or No	HIV/AIDS	Yes or No
Heart Attack and Year	Yes or No	IBS	Yes or No
High Blood Pressure	Yes or No	Liver Disease	Yes or No
High Cholesterol	Yes or No	Poor Circulation	Yes or No
Kidney Disease	Yes or No	Respiratory Disease	Yes or No
Pneumonia	Yes or No	Sickle Cell Anemia	Yes or No
Psych. Illness	Yes or No	Stroke and Year	Yes or No
Sleep Apnea	Yes or No	Tuberculosis	Yes or No
Seizure	Yes or No		

Do you have an immediate family history of any of the following? (Circle Yes or No and if yes, indicate relationship paternal or maternal)	
Heart Disease:	Yes or No, who:
Diabetes:	Yes or No, who:
Cancer:	Yes or No, who/type of cancer:
High Blood Pressure:	Yes or No, who:
Stroke:	Yes or No, who:
Thyroid Disease:	Yes or No, who:
Other:	

Surgical History (Procedure and Date):	
1	6
2	7
3	8
4	9
5	10

List Present Medications/Supplements/Vitamins and dosages:	
1	6
2	7
3	8
4	9
5	10

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HEALTH HISTORY

Personal Habits (Circle Yes or No):		
Exercise Regularly:	Yes or No	
Illegal Drugs:	Yes or No	
Eating Disorder:	Yes or No	
Adderall:	Yes or No	
Diet Medication:	Yes or No	
Vyvanse:	Yes or No	
Alcohol use:	Yes or No	If yes, how often:
Smoke:	Yes or No	If yes, how often:
or when did you stop smoking:		
Aspirin use:	Yes or No	If yes, how often:
Ibuprofen/Motrin:	Yes or No	If yes, how often:

Personal Information:		
Do you have history of MRSA:	Yes or No	If yes, explain:
Latex Allergy:	Yes or No	If yes, when were you tested:
Medication Allergy:	Yes or No	If yes, which medications:
Reaction to anesthesia?:	Yes or No	If yes, please explain:

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HIPAA and FINANCIAL DISCLOSURE

HIPAA DISCLOSURE

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal healthcare information is protected for privacy.

I understand that as part of my healthcare, this organization orginates and maintains health records describing my health history, symptoms, examination and test results, disagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

*a basis for planning my care and treatment.
* a means of communication among the many health professionals who contribute to my care.
*a source of information for applying my diagnosis and surgical information to my bill
*a means by which a third-party payer can verify that services billed were actually provided
*and a total for routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The Health Insurance Portability and Accountability Act, also known as HIPAA, was created in 1996 by the US Congress to protect the privacy of your health information. The act prohibits your health care providers from releasing your health care information unless you have provided our health care provider with a HIPAA release form. Unless you have provided a signed release form, your healthcare providers are prohibited from discussing any aspect of your medical information with anyone who is not directly involved in your care.

The *Notice of Information Practices* provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the rightto change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health info may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken acition in reliance theron.

FINANCIAL DISCLOSURE

During the course of your visits here at Salzman Cosmetic Surgery and Spa, the staff or Dr. Salzman may discuss, refer, prescribe or otherwise recommend products or services distributed, provided or endorsed by ALPHAEON Corporation. Dr. Salzman would like to inform all of his patients that he has ownership interest in Strathspey Crown Holdings, LLC, the parent company of ALPHAEON. We are providing this information to you in order to help you make an informed decision about your health care.

As always, you have the right to obtain health care services and products from Salzman Cosmetic Surgery and Spa as well as any other health care provider you choose. We completely respect your decision and will not treat you any differently if you choose to use or purchase a product or service other than those that we recommend. Upon request, we can provide information about alternative products or services. Also, in order to establish optimal relations with our patients and avoid musunderstandings regarding our payment policies, our staff is trained to inform you of our financial policies.

Upon scheduling an appointment, we will collect your credit card number and keep it on file. If you were to no show, cancel, or reschedule an appointment with less than 24 hour notice we will charge your card on file a $25 fee; however, all appointments that require a 20% deposit, will be charged the full deposit amount. Payment is expected from you for "your part" of the charges. We accept all major credit cards and checks for your convenience. Your signature below indicates that you understand and accept these policies. Furthermore, you acknowledge that if using a credit card or loan in someone else's name, we need written consent from the card/loan holder and should your Salzman account fall behind, at any point, you are responsible for any unpaid balance or disputed charges made by that card/loan holder.

By signing this form, you are authorizing that you have read the above information and understand its contents. You also agree that all of the health information that you have reported to us is true and correct to the best of your knowledge. If anything were to change with your health information, please update the office immediately.

Patient Name: (Please Print):	
Patient Signature:	**Date:**

If you want a copy of this page, please circle Yes and Alert the Front Desk Receptionist: YES OR NO