PATIENT INFORMATION

PLEASE PRINT DATE________________

NAME____

ADDRESS____

CITY____________________STATE_____ZIP________E-MAIL________________

OUT OF STATE ADDRESS____

HOME#________________CELL#________________WORK#________________

EMPLOYED BY________________________POSITION________________

MARITAL STATUS__________GENDER__________DATE OF BIRTH__________AGE______

SPOUSE OR PARENT/GUARDIAN INFORMATION:

NAME________________________RELATION TO PATIENT________________

EMPLOYED BY________________________PHONE#________________

RESPONSIBILITY FOR PAYMENT:

NAME________________________RELATION TO PATIENT________________

ADDRESS________________________PHONE#________________

GENERAL INFORMATION:

REFERRED BY____

REASON FOR SEEING DOCTOR/LIST PROCEDURE________________________

IF ACCIDENT –DATE OF INJURY____________DO YOU HAVE AN ATTORNEY FOR THIS PROBLEM?________

ARE YOU **ALLERGIC** TO ANY MEDICATION?________PLEASE LIST________________________

____

AUTHORIZATION FOR DISCLOSURE OF INFORMATION: I authorize Dr. Cristina F Keusch to disclose complete information concerning her medical findings and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who in Dr. Keusch's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

RELEASE OF INFORMATION/MEDICAL RECORDS: I hereby authorize Dr. Cristina F Keusch to release any information acquired in the course of my examination or treatment to my attorney's, physicians and /or insurance companies. I hereby authorize photocopies of this form to be valid as the original. This statement will remain in effect until revoked by me in writing.

DATE________________SIGNATURE________________________________

PHOTOGRAPHS: Pre and post-operative photographs are essential in plastic surgery, both for planning and for the analysis of post-operative results. It is the policy of this office that patients scheduled for surgery will have photographs taken before and after surgery. These photographs are intended solely for the use in this office. They cannot be shown to prospective patients nor can they be used in any talks or demonstrations without the expressed permission from you, the patient. I have read the above and fully understand the implications. I hereby give my consent to allow Dr. Keusch to take pre-operative, intra-operative and post-operative photographs of me.

DATE________________SIGNATURE________________________________

PRIVACY ACT: I authorize Dr. Keusch and her staff to call me, leave messages and confirm appointments, etc., in connection with my care. Please check the following:

HOME#_____CELL#_____WORK_____ DATE________ SIGNATURE________________________

MEDICAL INFORMATION

LIST ALL PREVIOUS SURGERY/HOSPITALIZATIONS, INCLUDING REASON:

Surgery-Hospitalization/Reason	Hospital	Type of Anesthesia	Year

ANESTHESIA COMPLICATIONS ______

LIST ALL MEDICATIONS YOU ARE TAKING, INCLUDING: EYE DROPS, OINTMENTS, VITAMINS/ HERBS

Medication	Dosage Amount	How Often Each Day

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD:

( ) Emphysema, Asthma, Bronchitis, Tuberculosis
( ) Diabetes
( ) Thyroid Disorders Hyper or Hypo, etc.
( ) Pancreas Disorders
( ) Stomach Problems, Ulcer
( ) Liver Disease, Hepatitis, Jaundice
( ) Kidney Disorders, Bladder Infections, Urinary Symptoms
( ) Pre-Menstrual Syndrome
( ) Pre /Peri /Post Menopausal CIRCLE ONE
( ) Stroke
( ) Cancer
( ) High or Low Blood Pressure
( ) Heart Murmur
( ) Irregular/Fast Heartbeat
( ) Angina
( ) Seizure Disorder/Epilepsy
( ) Rheumatic Fever
( ) Circulatory Problems
( ) Blood Transfusion Reactions
( ) Excessive Bleeding
( ) Headaches
( ) Fainting Spells/Syncope
( ) Glaucoma
( ) Cataracts
( ) Dry Eye Syndrome
( ) Radiation Treatment
( ) Arthritis
( ) Use of Acutane
( ) Psychiatric Treatment
( ) Prostrate Problems

YES	NO	
( )	( )	Do you have any skin problems? If yes, describe ______
( )	( )	Prone to cold sores: ______
( )	( )	Do you smoke? If yes, how much per day? E-cigarettes or vaping? ______
( )	( )	Are you a former smoker? If yes, when did you stop smoking? ______
( )	( )	Do you drink alcoholic beverages? If yes, how much per day? ______
( )	( )	Do you have vision problems? If yes, explain: ______
( )	( )	Do you wear eyeglasses? ______ Do you wear contact lenses? ______
( )	( )	Do you wear removable dental appliances/dentures? ______
( )	( )	Do you have dental caps or crowns? ______
( )	( )	Do you now, or have you ever used "street drugs"? ______
( )	( )	Are you pregnant? ______
( )	( )	Do you have any allergies to foods, medications or environment? If yes, explain: ______
( )	( )	DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK THE DOCTOR SHOULD KNOW ABOUT? IF YES, EXPLAIN: ______

PRIVATE/PERSONAL PHYSICIAN: ______ Date of Last Exam ______

ADDRESS ______ TELEPHONE#: ______

Last known blood pressure ______ Date of last EKG ______ Chest X-Ray ______ Mammogram ______

HEIGHT ______ CURRENT WEIGHT ______

I HAVE READ (or have had read to me) THE ABOVE MEDICAL INFORMATION LISTED AND I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Signed ______ **Date** ______

(Parent/Guardian, if patient is a minor)

Cristina F. Keusch M.D., P.A., F.A.C.S.
DIPLOMATE AMERICAN BOARD OF PLASTIC SURGERY
DIPLOMATE AMERICAN BOARD OF SURGERY
FELLOW AMERICAN COLLEGE OF SURGEONS

DATE_______

People with whom we can discuss your healthcare:

Name ____

Relationship____

Contact No.____

Name ____

Relationship____

Contact No.____

Name ____

Relationship____

Contact No.____

______________________________ ______________________________
Patient name (print) Patient signature

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950 Glades Road Suite 3A • Boca Raton, FL 33431
561-368-9455 • Fax 561-394-8210 • www.DrKeusch.com

MEMBER
THE AMERICAN SOCIETY FOR AESTHETIC PLASTIC SURGERY
The Mark of Distinction In Cosmetic Plastic Surgery®

CRISTINA F. KEUSCH, M.D., P.A., TELEPHONE NUMBER: 561-368-9455

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The notice contains a patient rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict your protected health information regarding treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The practice has a Notice of Privacy practice and that the patient has the opportunity to review this notice
- The practice reserves the right to change the Notice of Privacy practices
- The patient has the right to restrict the uses of their information but the practice does not have
- to agree with those restrictions
- The patient may revoke this consent in writing at any time and all future disclosures will then cease
- The practice may condition receipt of treatment upon the execution of this consent
- For the patient's convenience, the patient may choose to allow the practice permission to leave protected health information on certain answering machines, emails, voicemail, as selected and approved by the patient below

PATIENT NAME:____DATE:______________
SIGNATURE:____________________________________RELATIONSHIP TO PATIENT:______________

Appointment reminders may be left on my ____**Cell Phone** ____**Home Phone**
____ **Check here if you do NOT want messages left**

Biopsy results may be left on my ____**Cell Phone** ____ **Home Phone**
____**Check here if you do NOT want messages left**

Medical information (prescription refills, etc.) may be left on my ____**Cell Phone** ____ **Home Phone**
____**Check here if you do NOT want messages left**

I allow the release of my health information to the following person(s): (*please print names clearly*)
Name:____________________________________Relationship to Patient:______________________
Name:____________________________________Relationship to Patient:______________________

By signing, I acknowledge that I will disclose all of my health information known to me at this time and that all of my other personal information is accurate.

Signature:____Date:______________________________

Cristina F. Keusch M.D., P.A., F.A.C.S.
DIPLOMATE AMERICAN BOARD OF PLASTIC SURGERY
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PATIENT CONSENT FOR USE OF CREDIT CARDS, DEBIT CARDS AND FINANCING

DISCLOSURE OF PROTECTED HEALTH INFORMATION

It may be necessary to release your protected health information to financial parties, credit card entities, banks and financing companies, when requested to facilitate your payment.

Services that are performed that are paid with a credit card, debit card or financing third party are not eligible for payment challenges after services are provided. Non-refundable deposits are also not eligible for payment challenges. By signing this form, I am irrevocably consenting to allow Cristina F. Keusch, M.D., P.A. to use and disclose my protected health information to any Credit Card Entity, Bank or Financing Company when they request such information to process an account and assist payment.

I will not challenge such credit, debit or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise.

I agree that this non credit card challenge agreement is irrevocable.

Signature of Patient or Legal Guardian____

Print Patient's name__________________________________ Date__________________

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TELEPHONE/TEXT MESSAGE CONSENT

I CONSENT TO RECEIVE CALLS AND/OR TEXT MESSAGES FROM DR. CRISTINA KEUSCH AND HER OFFICE FOR MY PROTECTED HEALTHCARE AND OTHER SERVICES AT THE TELEPHONE NUMBER(S) PROVIDED, INCLUDING MY WIRELESS NUMBER PROVIDED. I UNDERSTAND I MAY BE CHARGED FOR SUCH CALLS/TEXTS BY MY WIRELESS CARRIER AND THAT SUCH CALLS/TEXTS MAY BE GENERATED BY AN AUTOMATED DIALING SYSTEM.

PATIENT'S NAME____

AGREED TO BY____

DATE SIGNED____

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