THE AESTHETIC CENTER
PLASTIC SURGERY
& MEDICAL SPA

Welcome to Our Office

Thank you for choosing our office. In order to serve you properly, PLEASE PRINT the following information.			
Name:		DOB:	
Address:		City/State/Zip:	
Last 4 digits of SSN:	Marital Status:	Gender:	
Home #:	Work #:	Cell #:	Other:
May we contact you by email? Yes or No	Email Address:		
Employer:	Address:		
Occupation:		Full/Part/Student/Retired/Other:	
Emergency Contact Name:			Relationship:
Emergency Contact Home #:		ER Contact Cell #:	
How did you hear about us:		Referring Doctors Name:	
Pharmacy Name & Address:			Pharmacy #:
What Procedure(s) are you interested in?			
Are you the primary on the Insurance: Yes or NO		If NO please provide primary insurers Name & DOB:	
Do you have secondary insurance?	Name on policy:		Group No:
If Workers Compensation, treatment authorized by:			Claim #:
Pharmacy Name & Address:			

I authorize this office to release to the named insurance company any information necessary to expedite insurance payment: I understand that I am responsible for all charges, regardless of insurance coverage.	
Patient or Parent/Guardian Signature:	Date:

FREDRIC NEWMAN, MD • DAVID PASSARETTI, MD • LEO OTAKE, MD • YUEN-JONG LIU, MD
722 Post Road • Darien, CT 06820 • T 203. 656. 9999 • F 203. 655. 0099 • TheAestheticCenter.com

THE AESTHETIC CENTER PLASTIC SURGERY & MEDICAL SPA

(203) 656-9999

Health Information as of ______________ (enter today's date) Please print legibly & fill in or correct all fields.

Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Name: ________________________ Reason for Visit: ________________________

Age: ____________ Height: ________ Feet ________ Inches Weight: ____________ Lbs.

Current Physician(s): ____

List all surgeries (hospitalization and the date of occurrence):

List any serious illnesses and/or accidents:

Do you have or have you had any of the following: (circle for each, add date occurred if Yes)

AIDS / HIV	No	Yes	Epilepsy / Seizures	No	Yes	Kidney Problems	No	Yes
Arthritis	No	Yes	Facial Pain	No	Yes	Pneumonia	No	Yes
Asthma	No	Yes	Fever Blisters	No	Yes	Sinus Problems / Infections	No	Yes
Bronchitis	No	Yes	Goiter / Thyroid	No	Yes	Stroke	No	Yes
Cancer	No	Yes	Hay Fever / Allergies	No	Yes	Tonsillitis	No	Yes
Depression	No	Yes	Headaches / Migraine	No	Yes	Tuberculosis	No	Yes
Diabetes	No	Yes	Heart Trouble	No	Yes	Ulcers	No	Yes
Dizziness / Vertigo	No	Yes	Hepatitis	No	Yes	Fainting	No	Yes
Ear Infection	No	Yes	High Blood Pressure	No	Yes			

Do you smoke?	No	Yes	If so how much? ______ pack(s) per day	How long?_______ months/years
Do you drink alcohol?	No	Yes	If so how many? ______ per day	How often? _________________
Do you use recreational drugs?	No	Yes	If yes, explain:______________________________	
Do you have bleeding/bruising problems?	No	Yes	If yes, explain:______________________________	
Do you have problems with scarring?	No	Yes	If yes, explain:______________________________	
Do you have any history of problems with anesthesia?	No	Yes	If yes, explain:______________________________	

List the name of all medications you are presently taking or have taken within the last month.
Please include the name of the drug, dosage and frequency.

List ALL drug and/or latex allergies. Please state NONE if you do not have any.

The above information is accurate and complete to the best of my knowledge.

Signature ________________________________ **Date** ________________

PHI CONSENT

Patient Consent for Use and Disclosure of Protected Health Information

By signing this form, I consent to the use and disclosure of my protected health information by physicians Fredric Newman, MD, David Passaretti, MD, Leo Otake, MD, Yuen-Jong Liu, MD and the staff and business associates, strictly for the purpose of treatment, payment and healthcare operations.

I acknowledge that I have had an opportunity to review the Notice of Privacy Practices prior to signing this consent. The physicians and the staff have encouraged me to review the Notice of Privacy Practices which provides detail on how my information may be used and disclosed. The Notice of Privacy Practices may change. A current copy may be requested when I am being seen as a patient, by contacting my physician at the office.

I may request restriction on how protected health information is used and disclosed for the purposes mentioned above. I will make a request for restriction in writing. The physicians mentioned above, reserves the right to deny the request. If the request is granted, I am bound by the terms of the agreement.

I may also revoke this consent in writing; however, information on any treatment or service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment, or healthcare operations. Refer to the Notice of Privacy Practices for further information.

By signing this form, I grant my consent to the medical practice to use and disclose my protected health information for the purposes of treatment, payment, and healthcare operations.

____ _______________
Patient or Parent/Guardian Signature Date

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